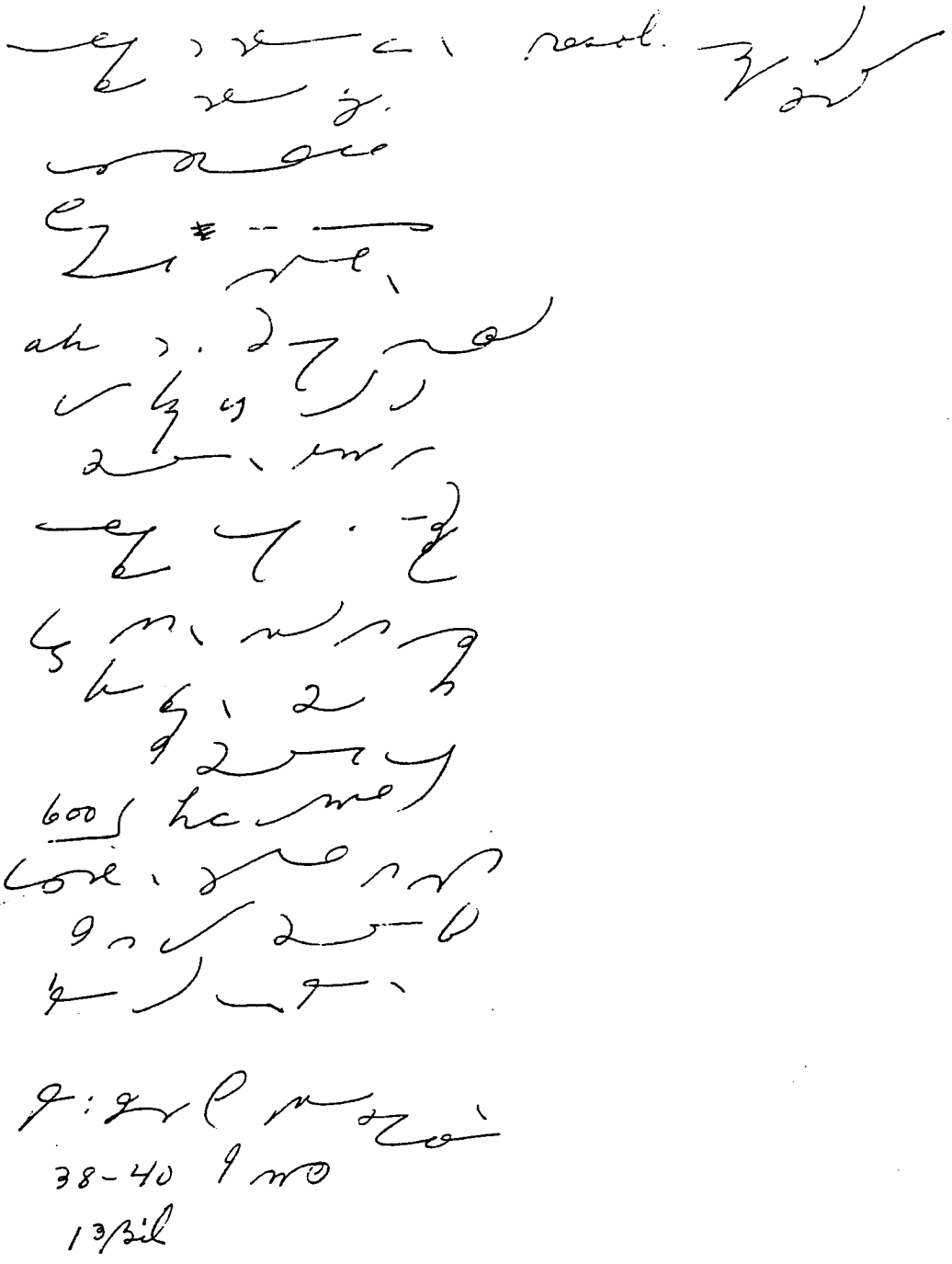
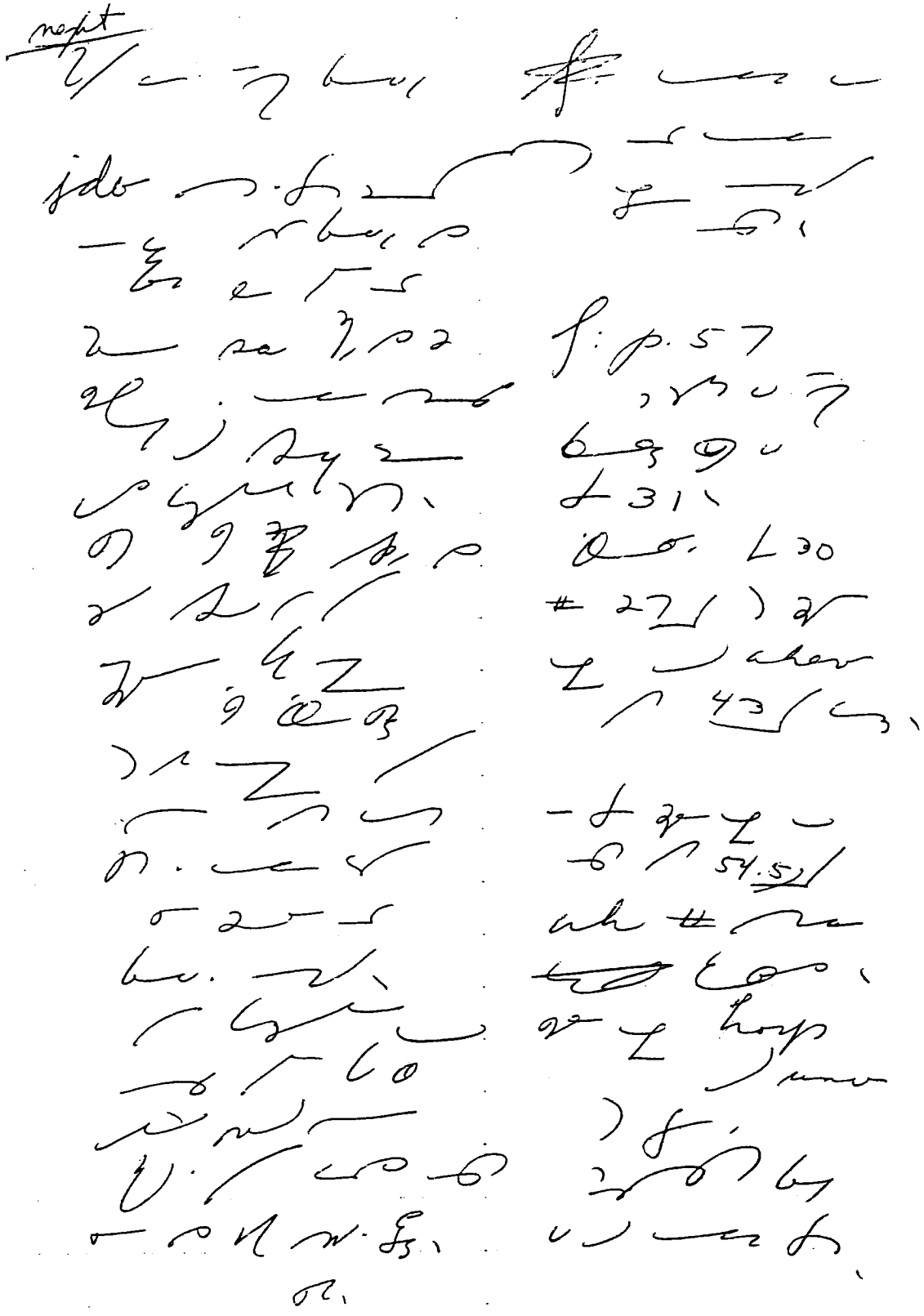
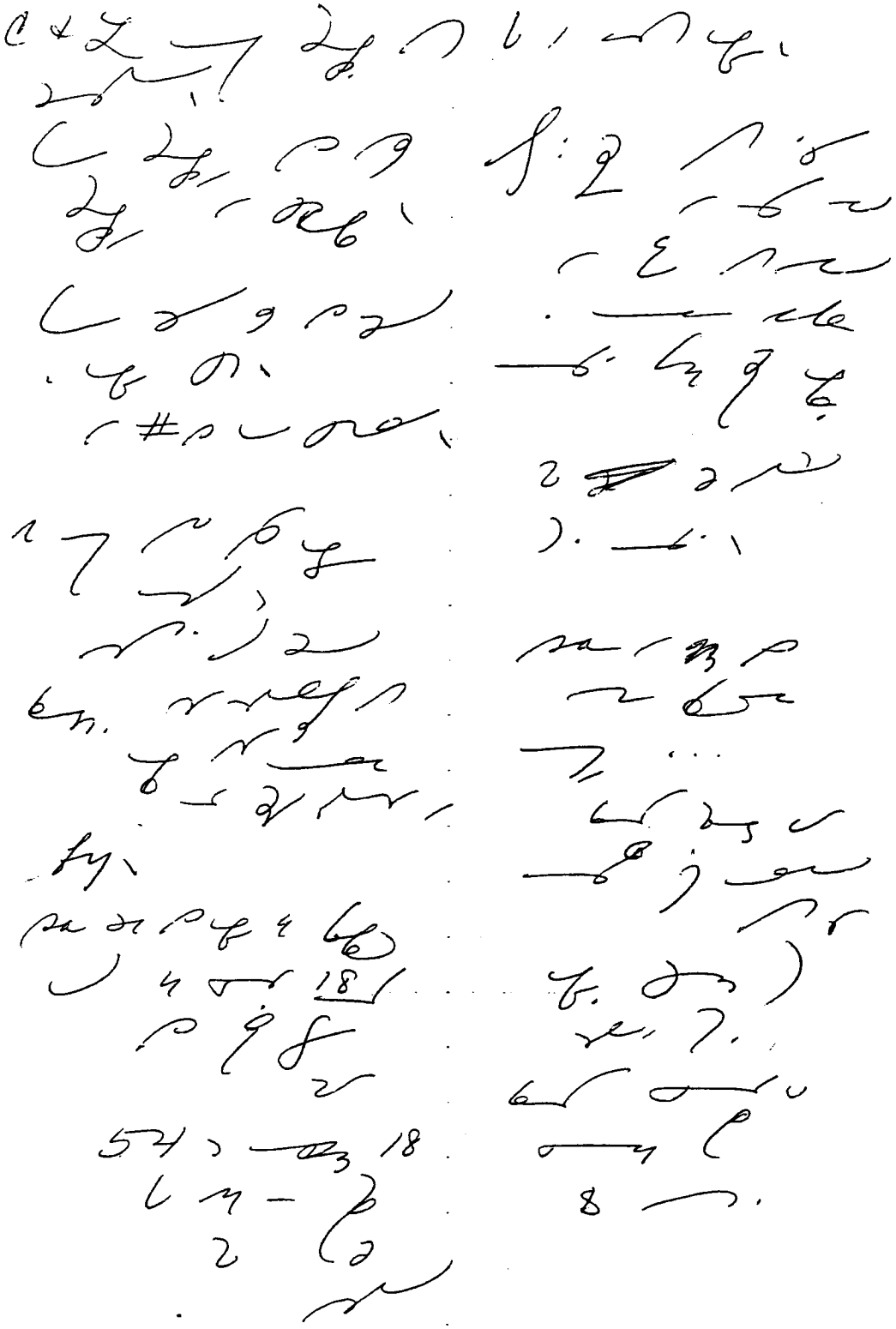
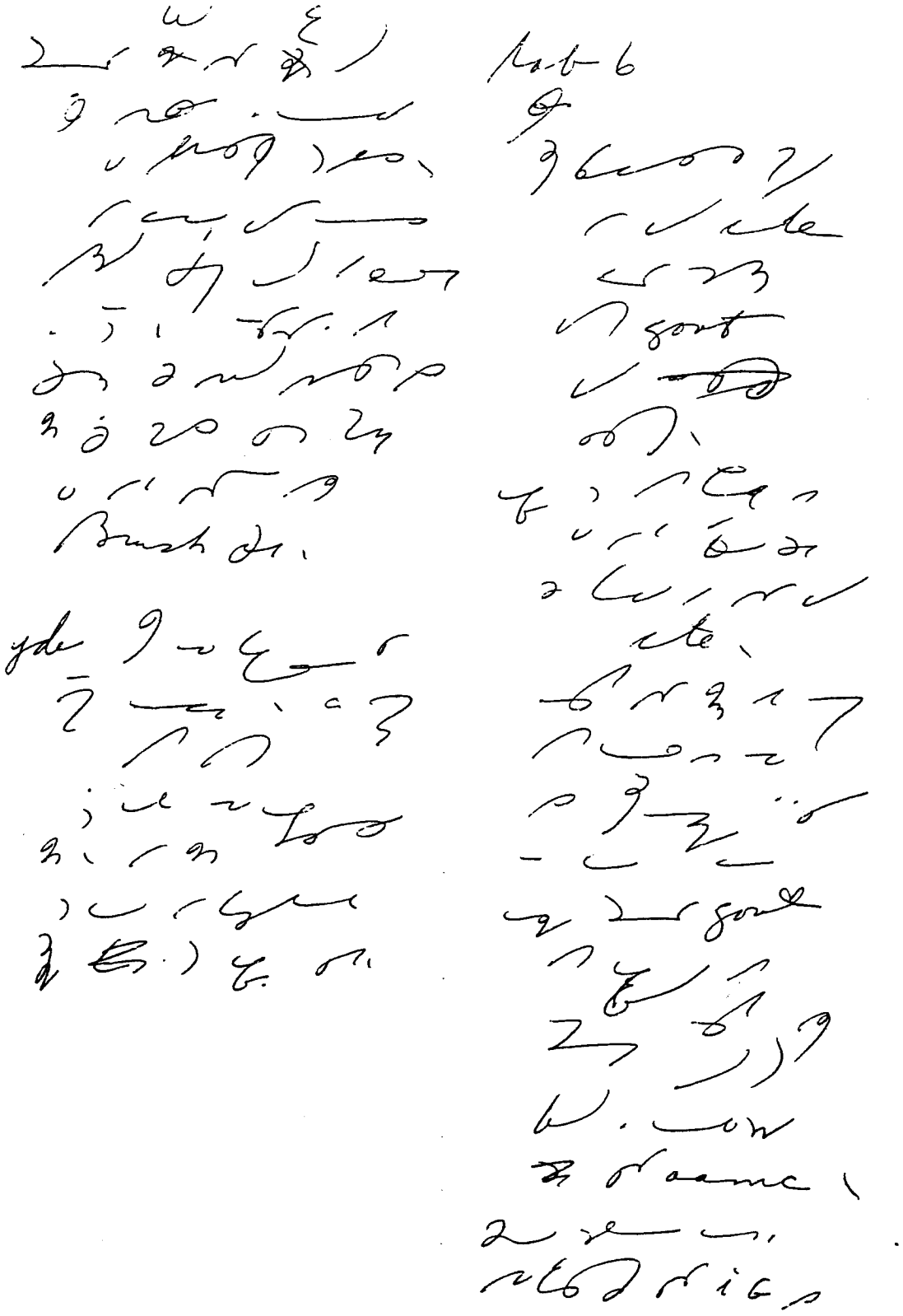
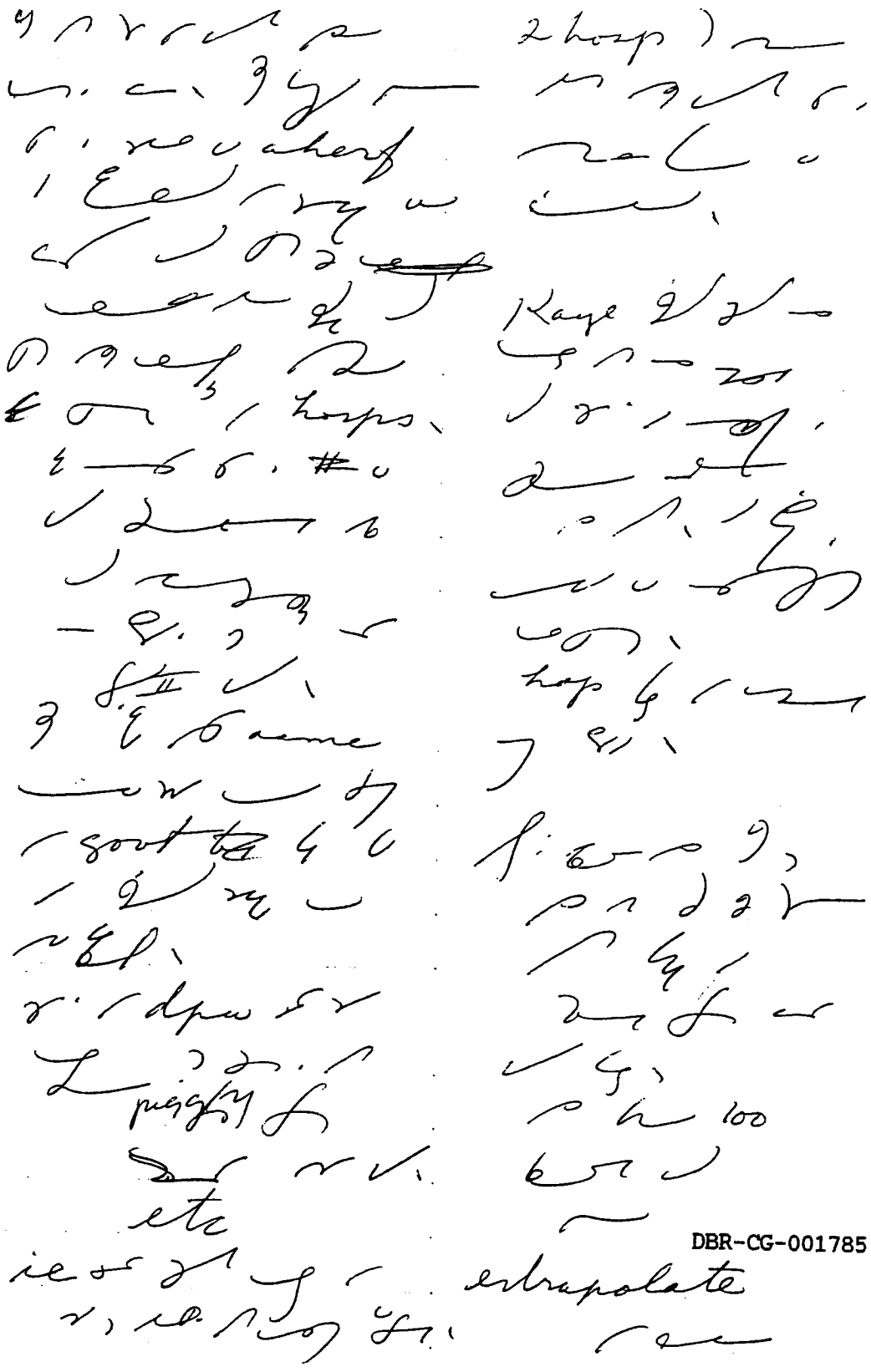


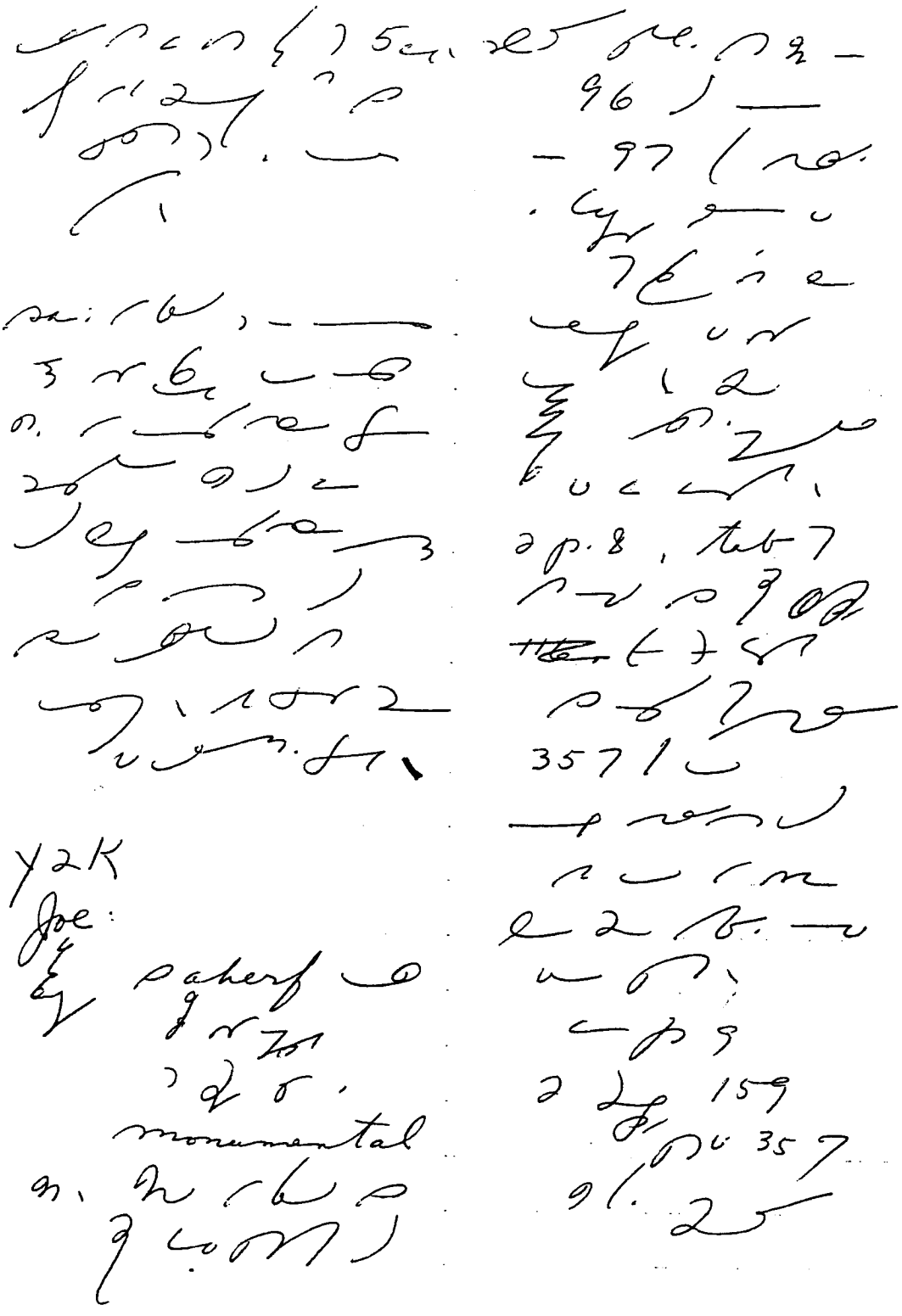




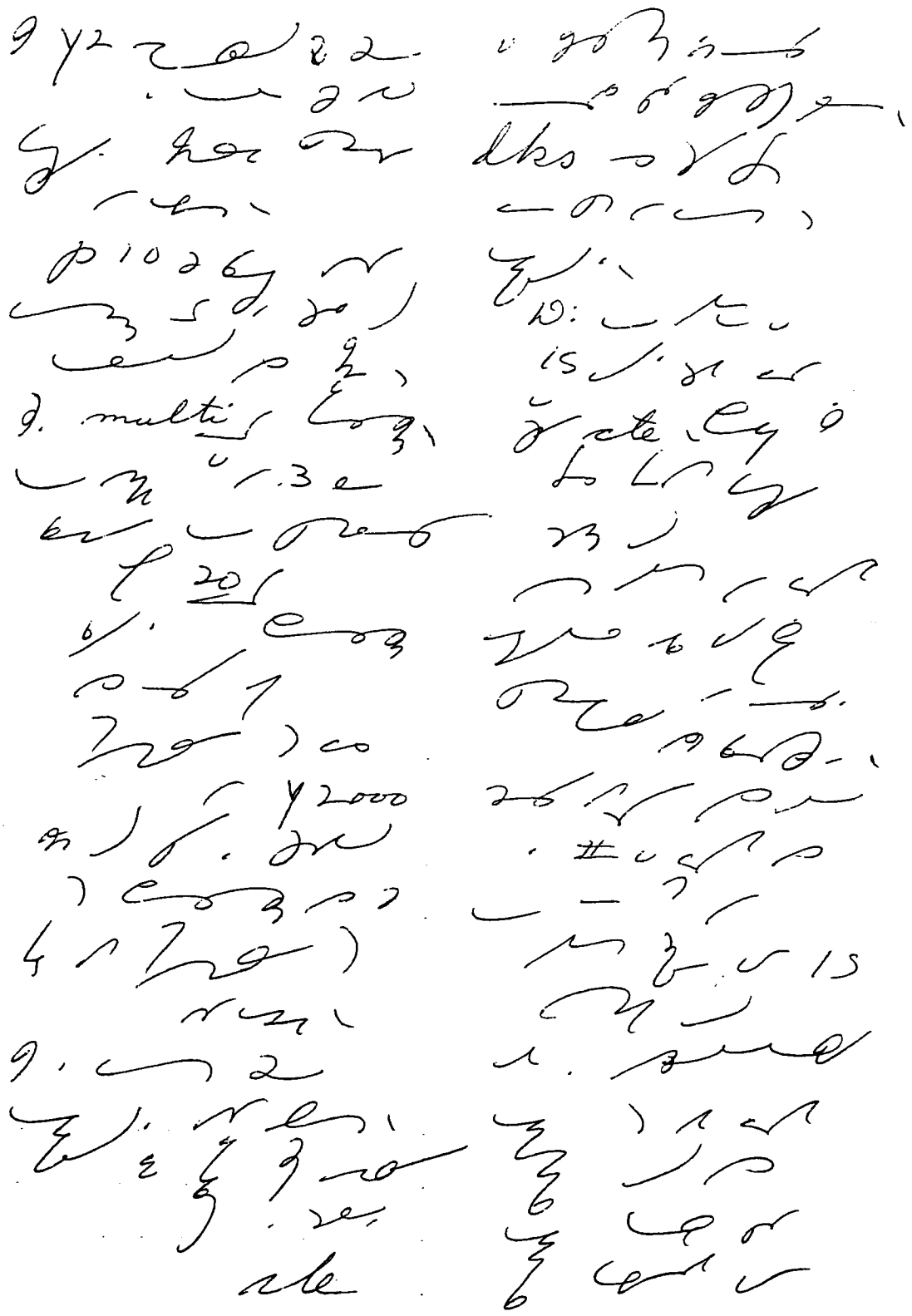


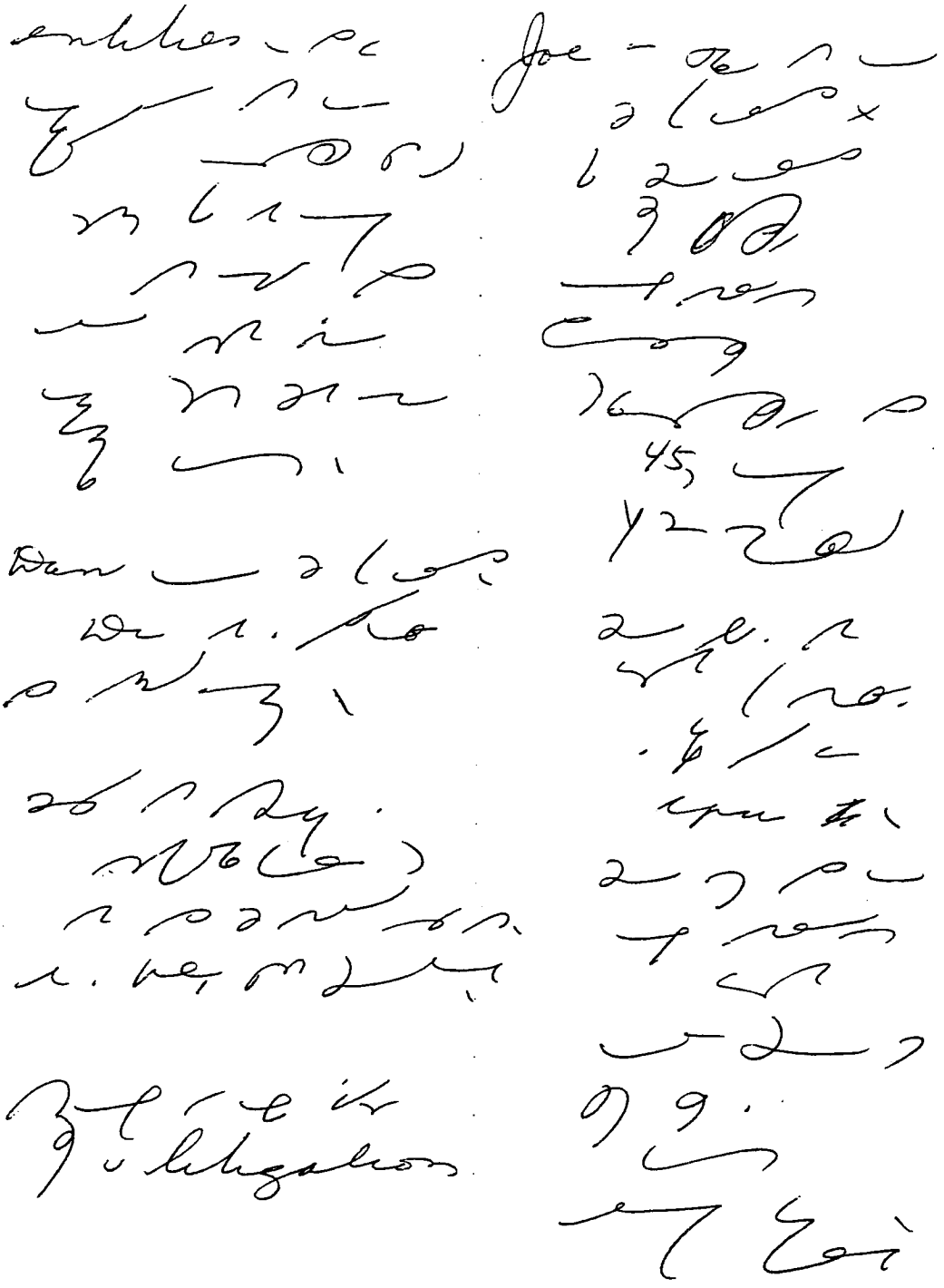


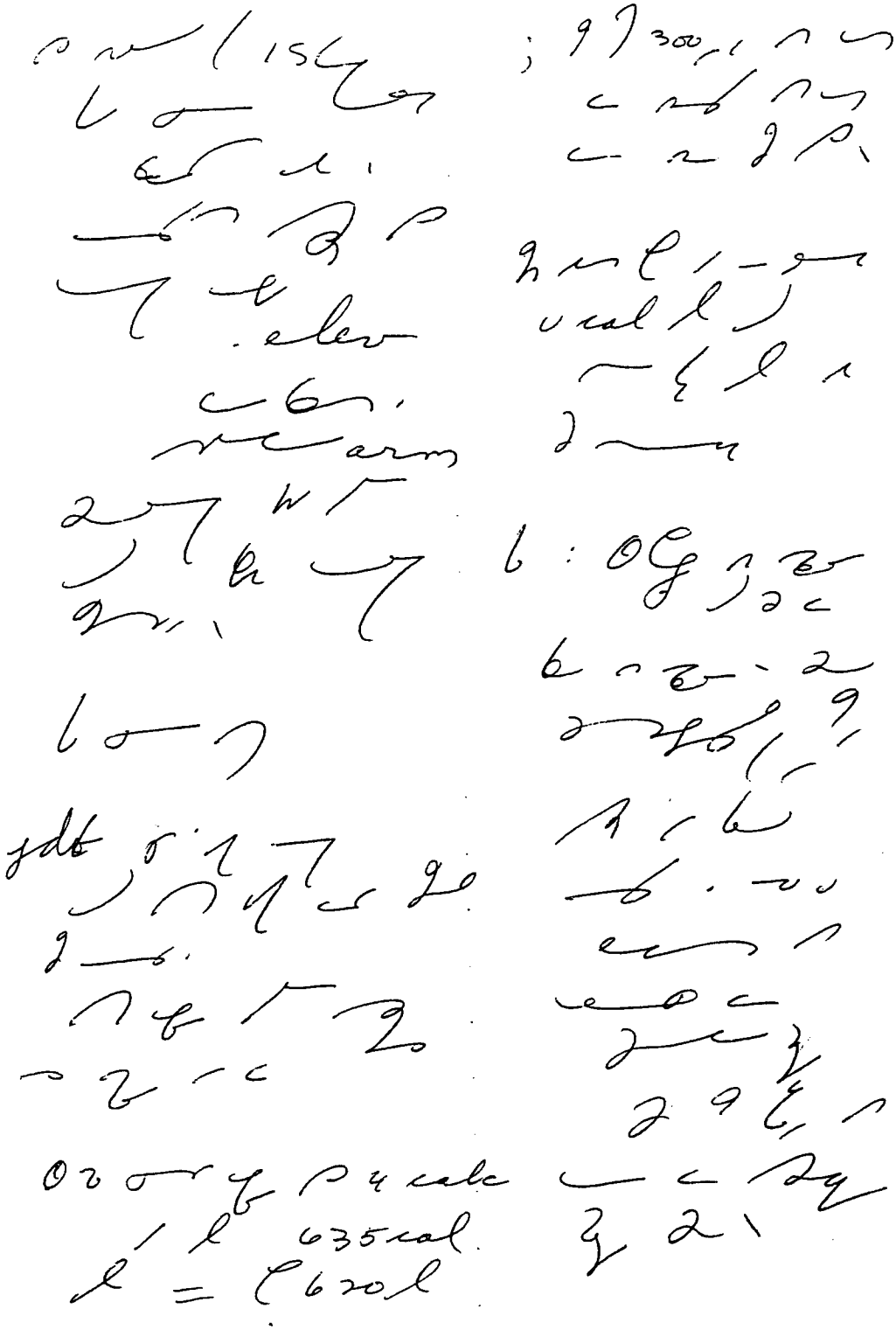
DBR-CG-001785

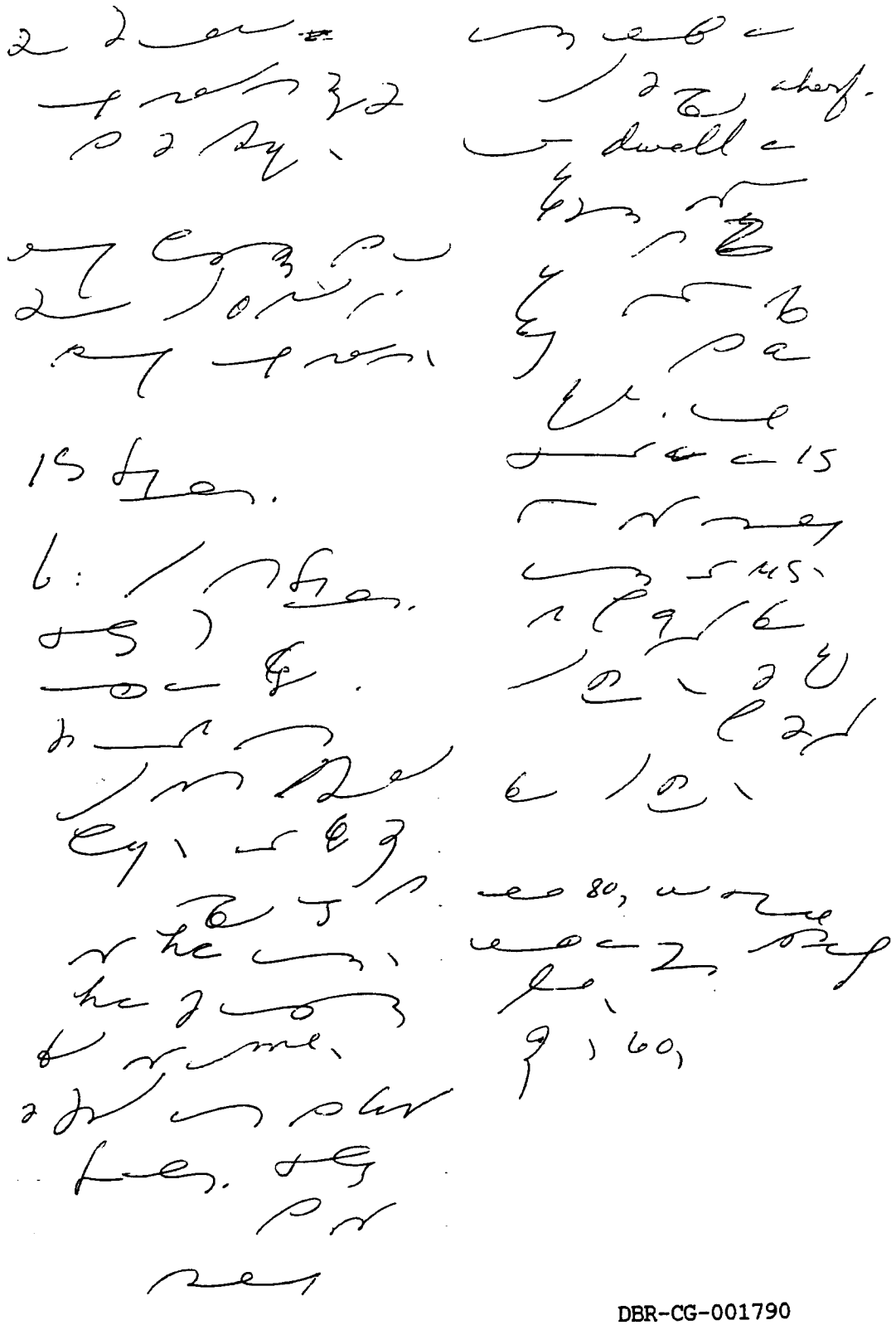


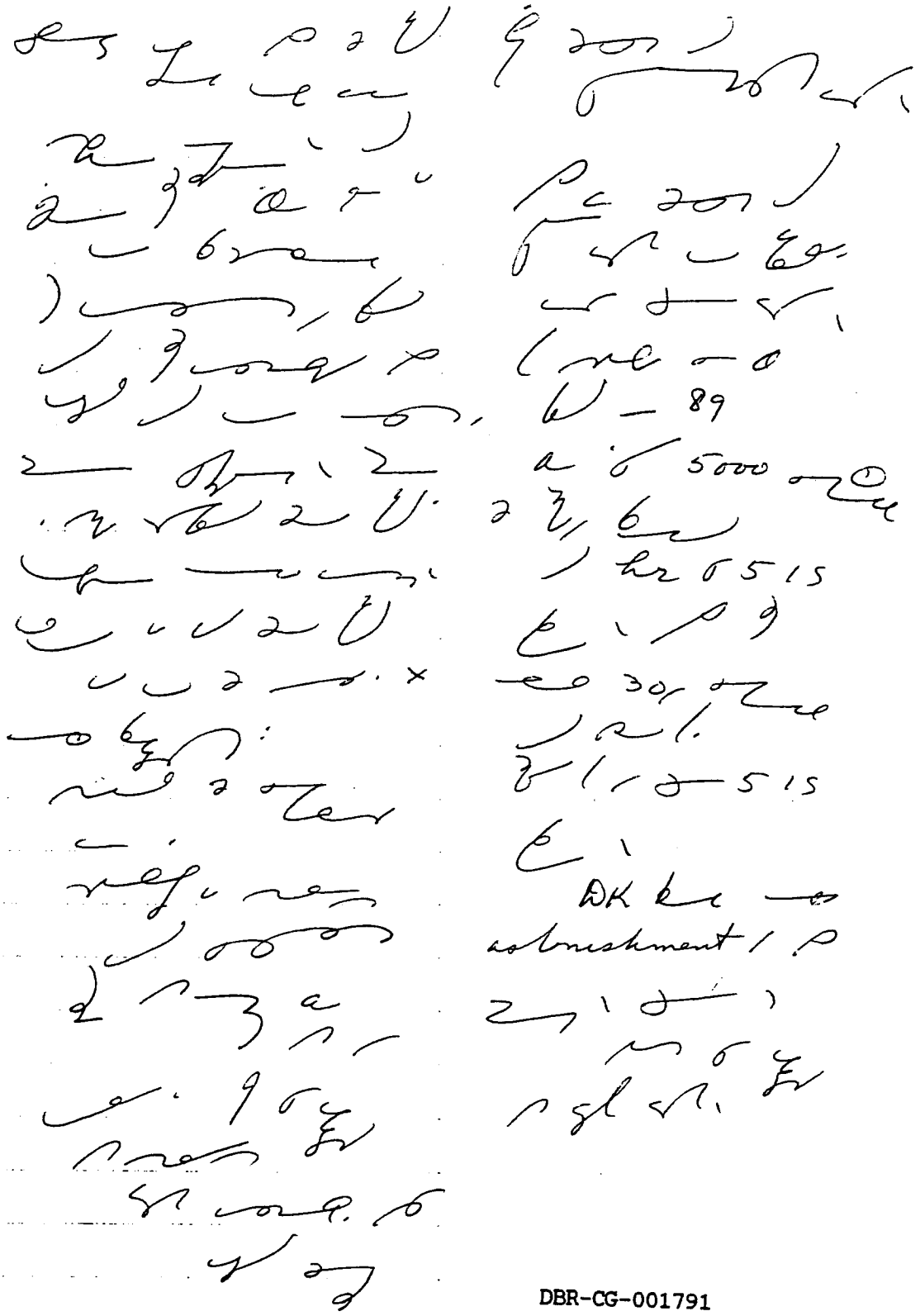
Y2K
Joe:

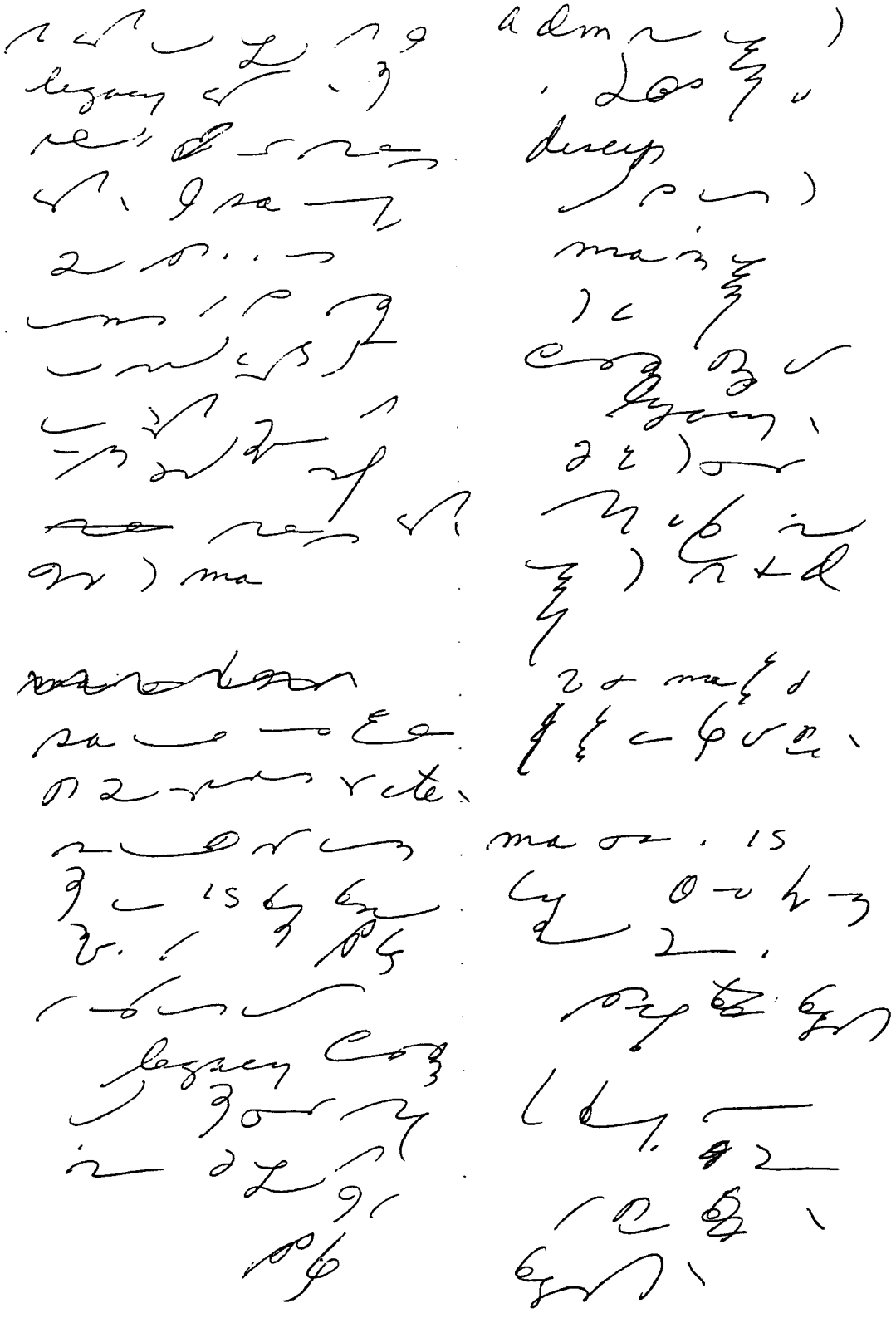


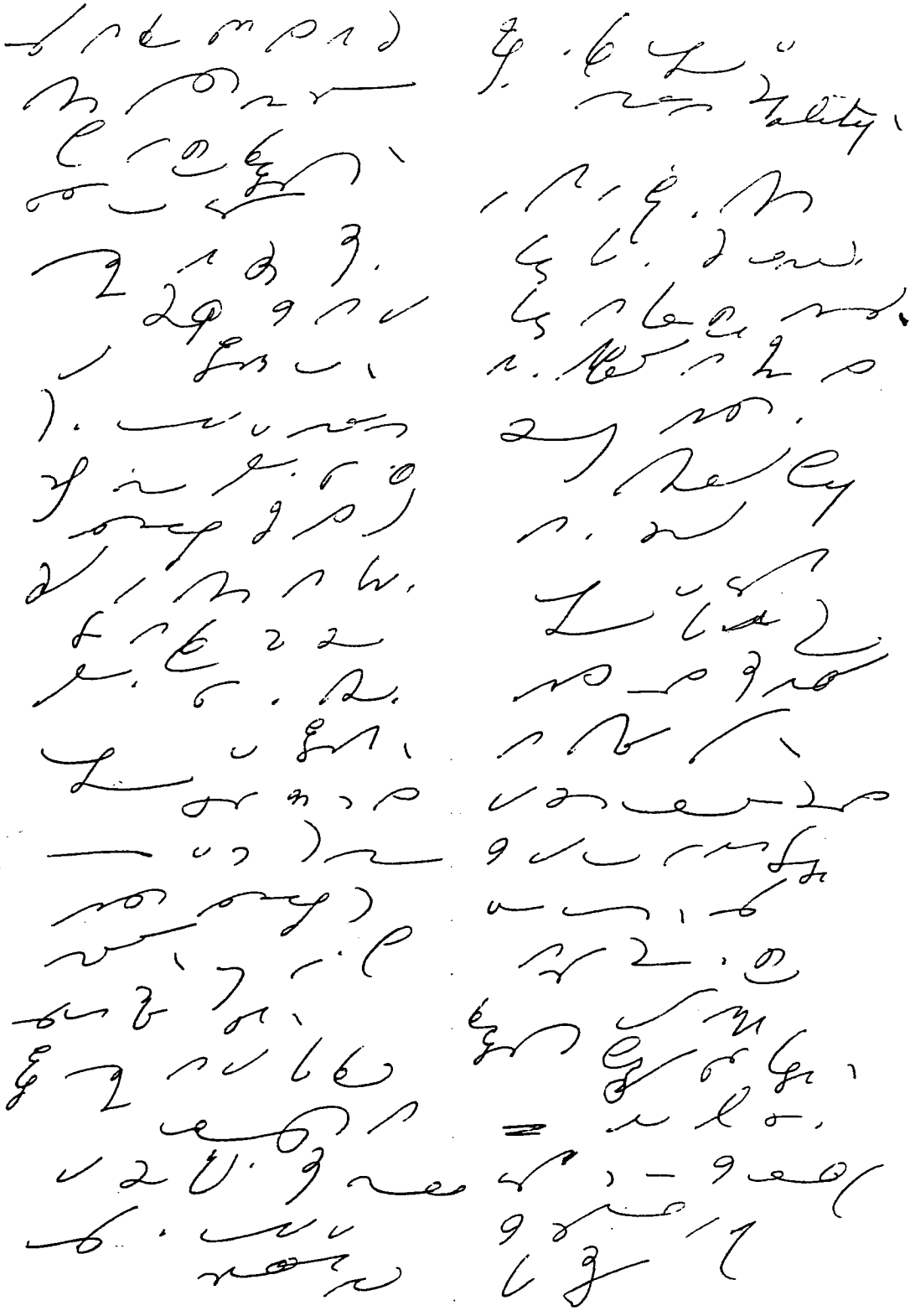


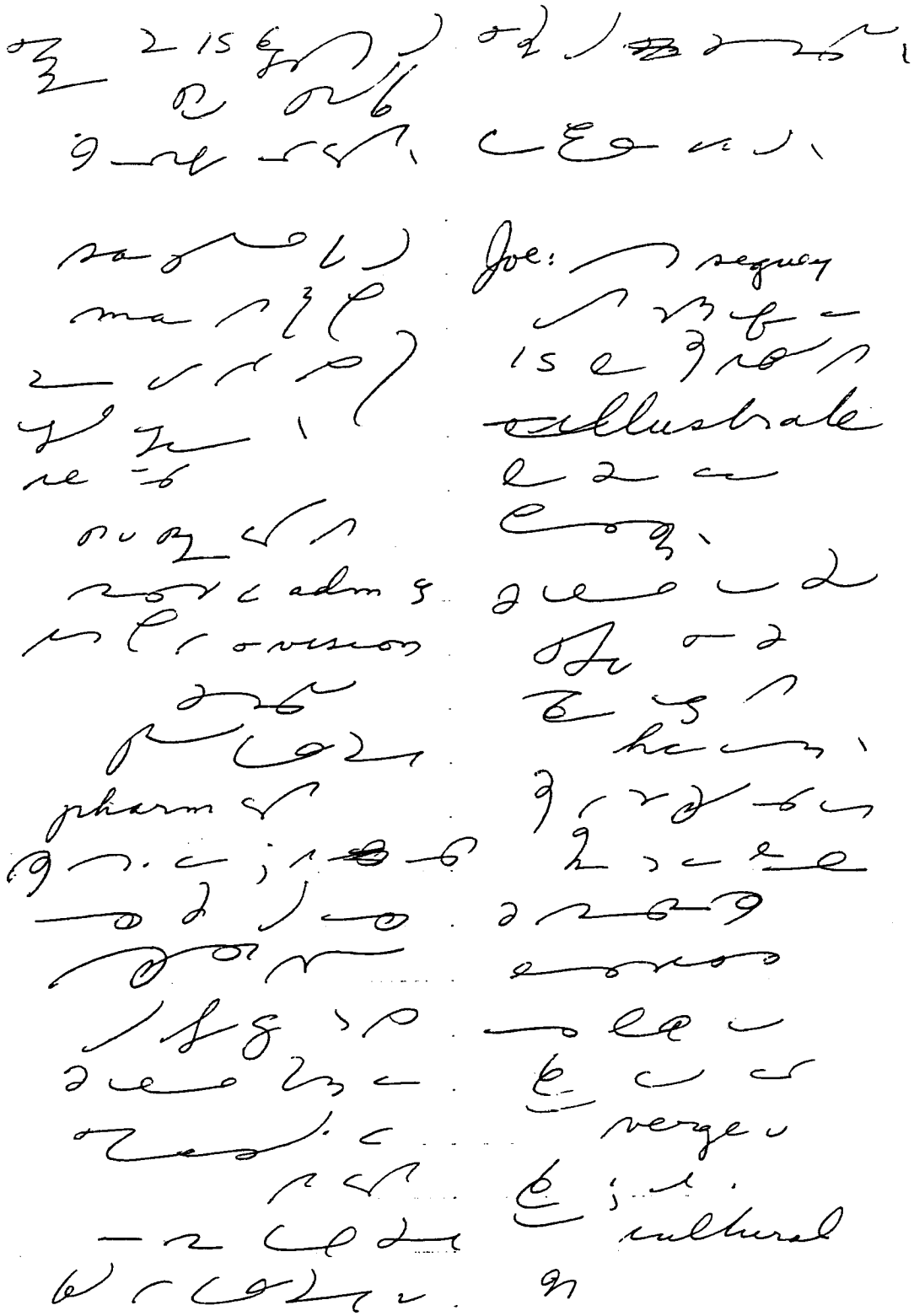


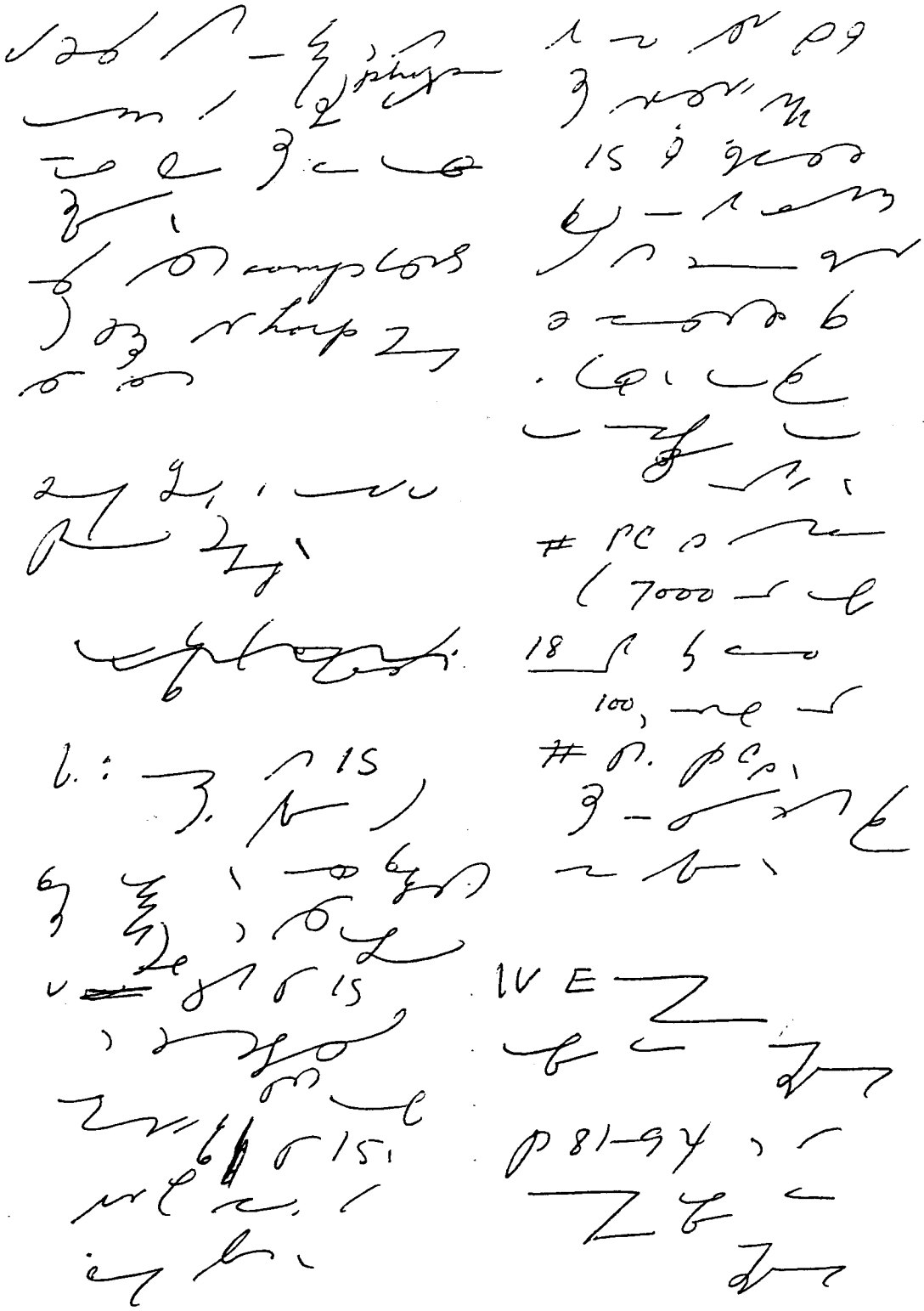


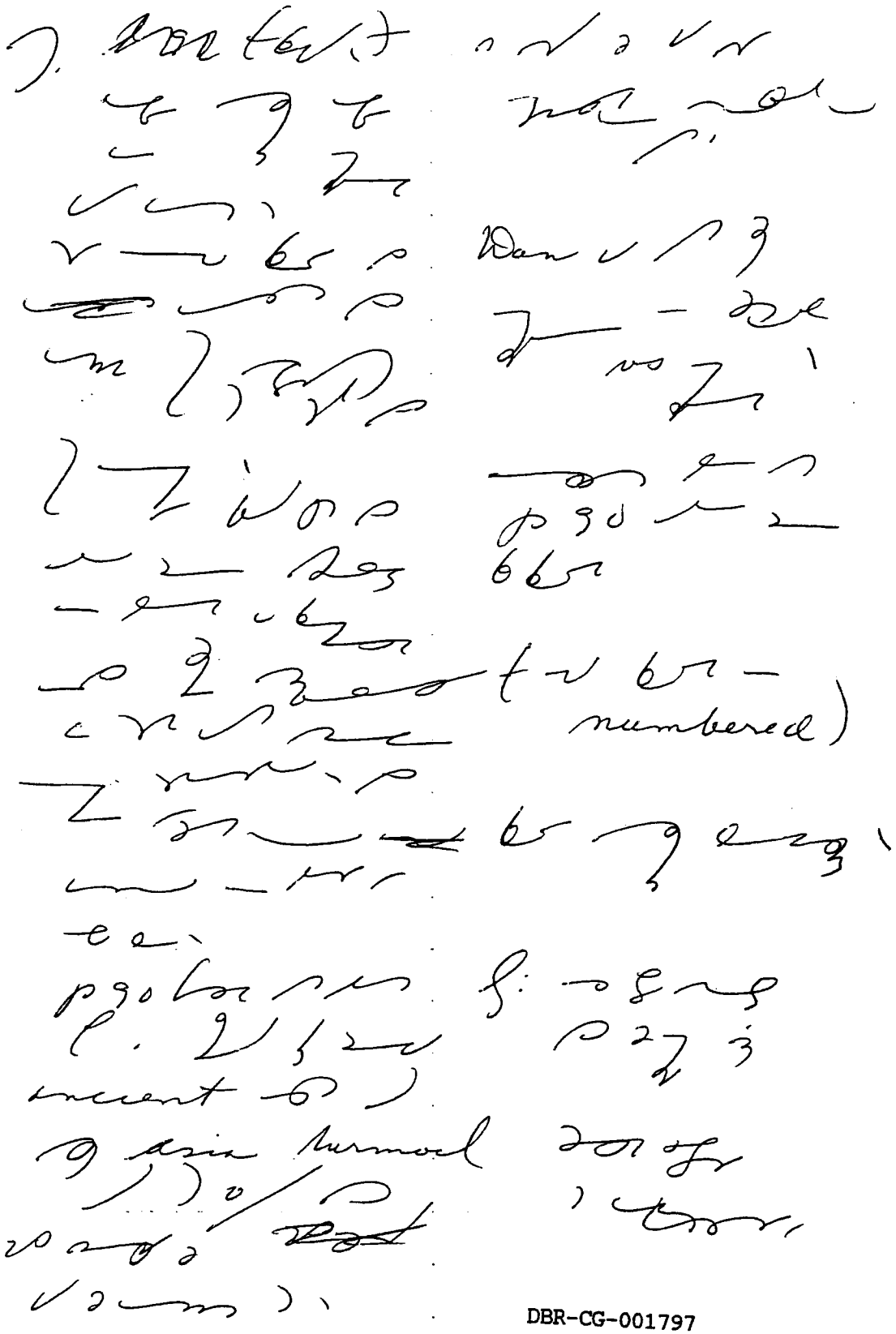


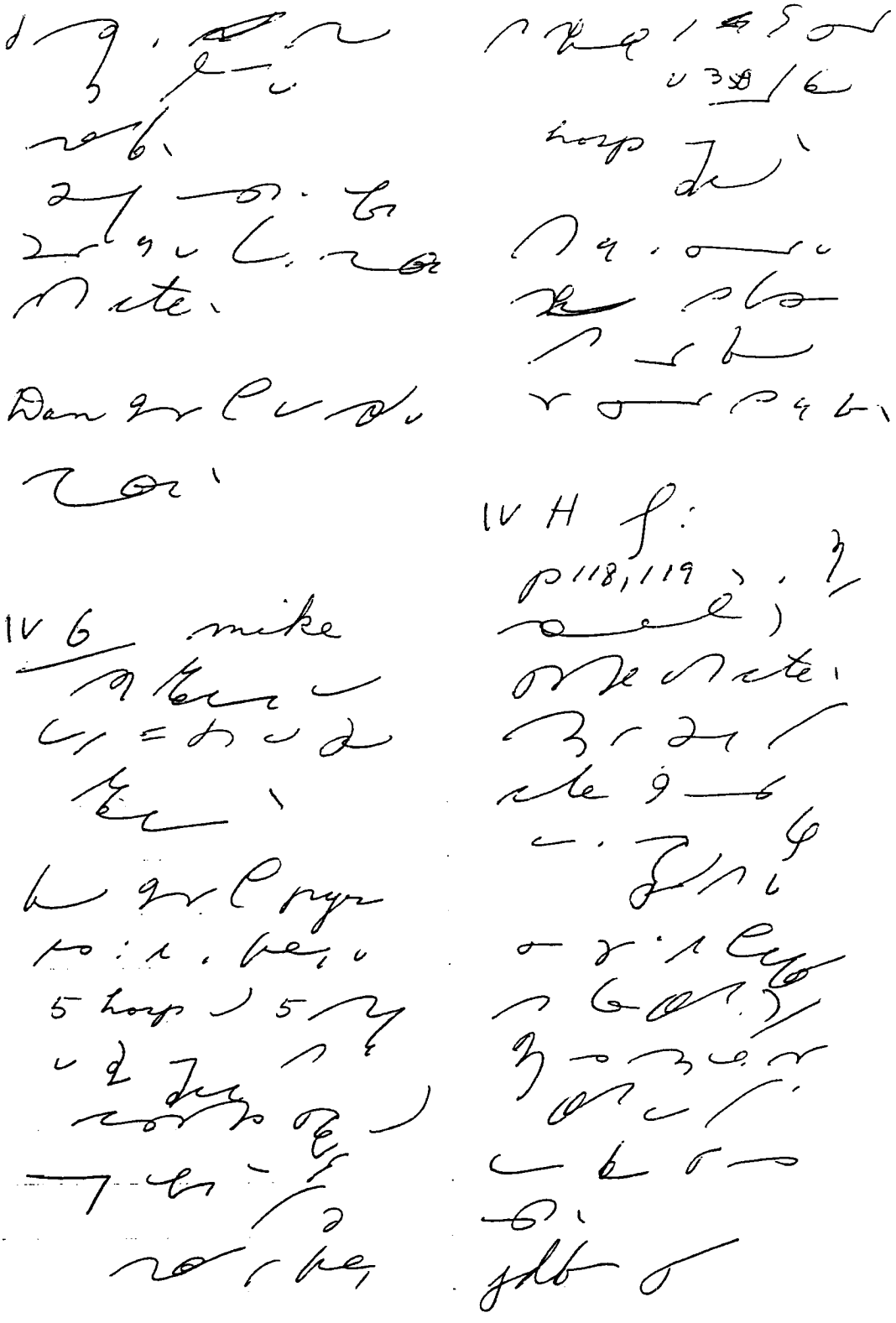


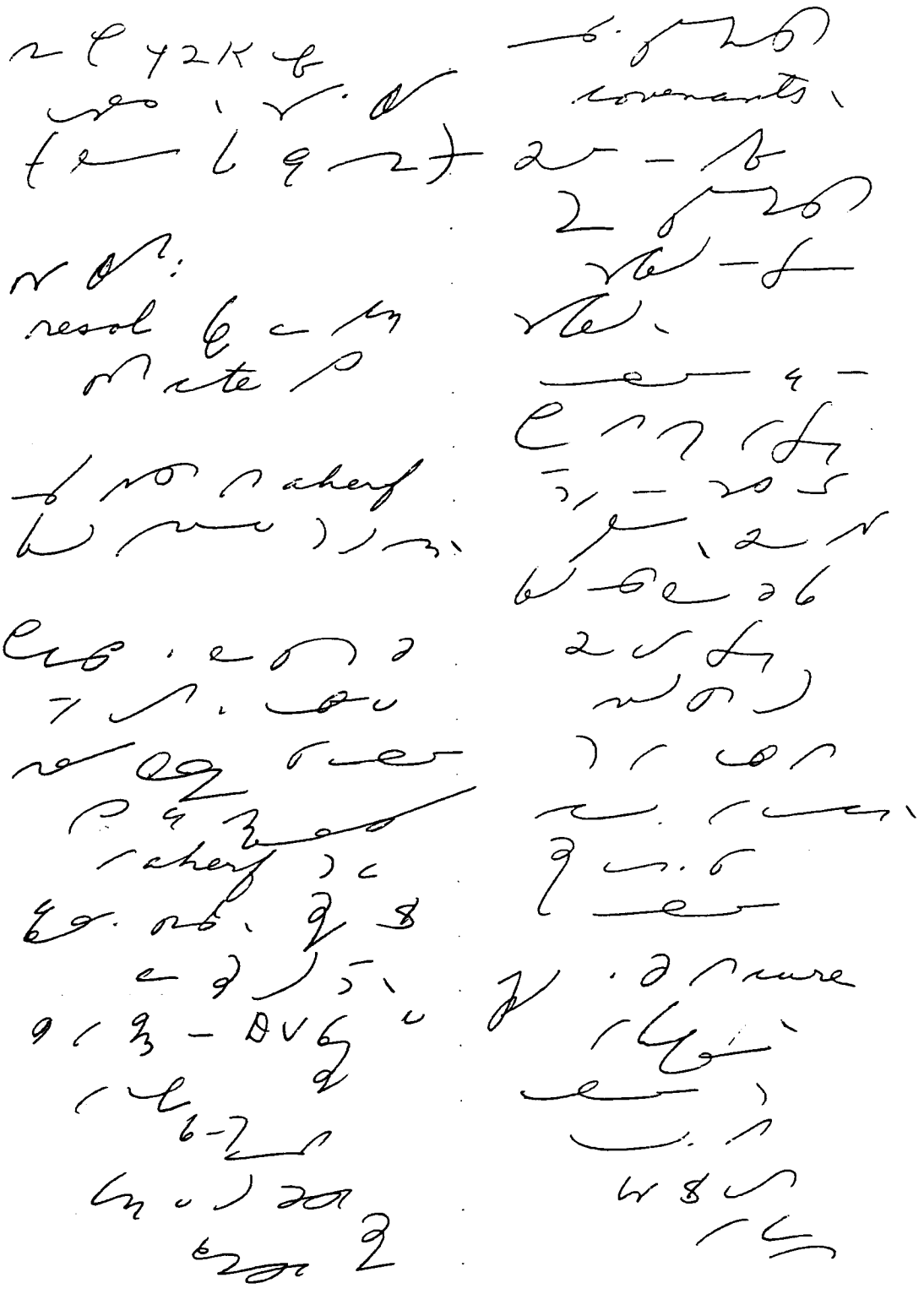


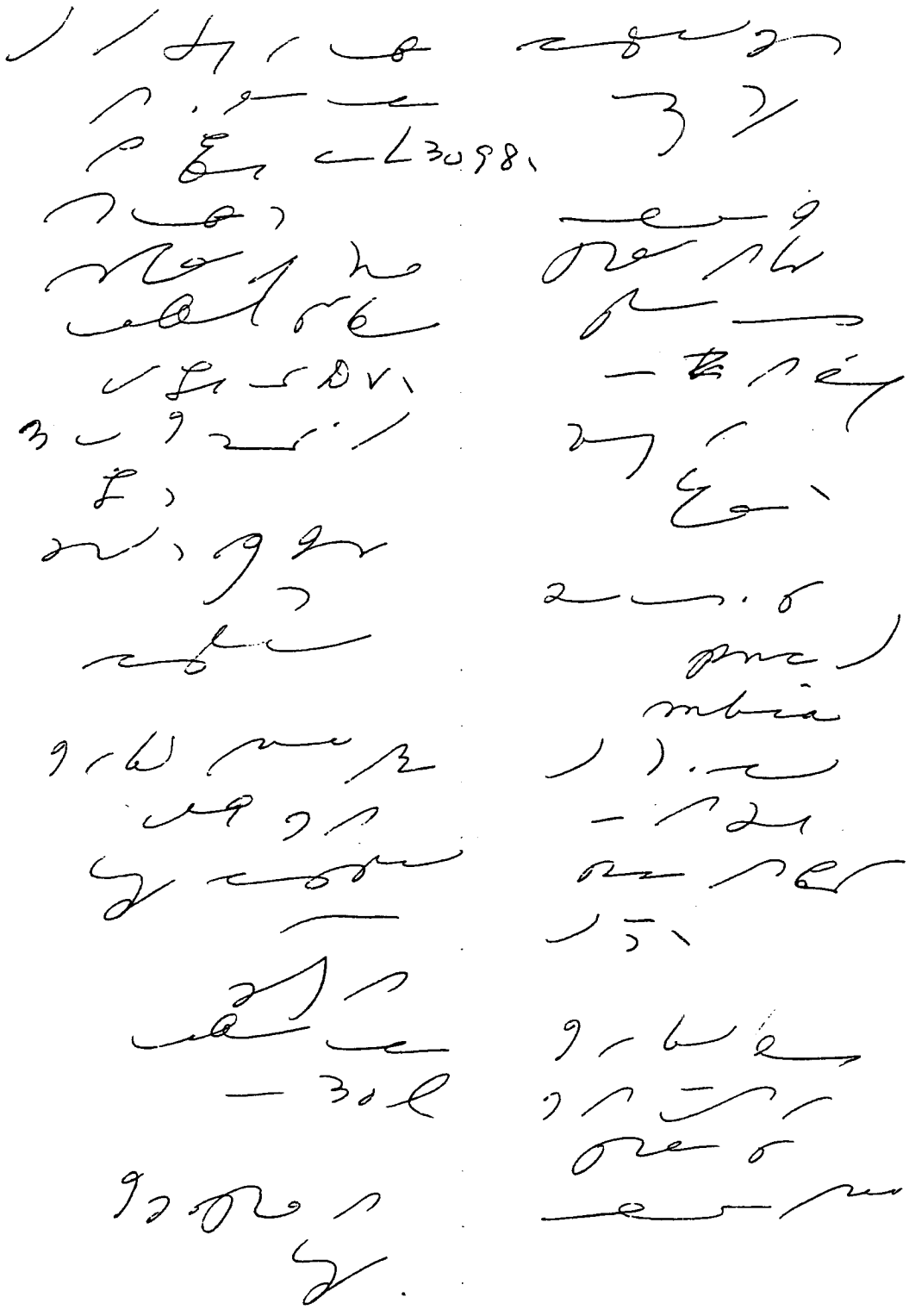


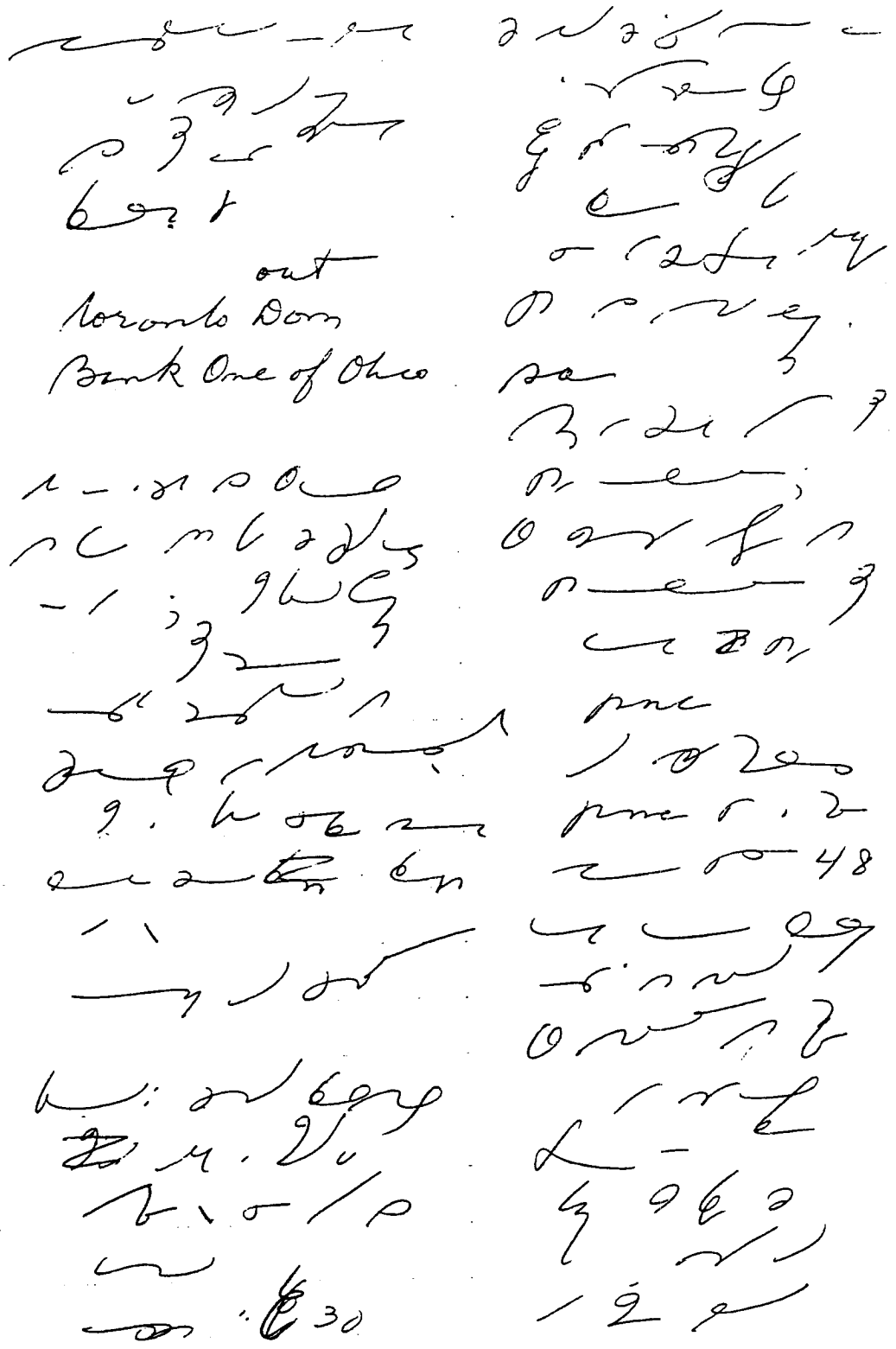


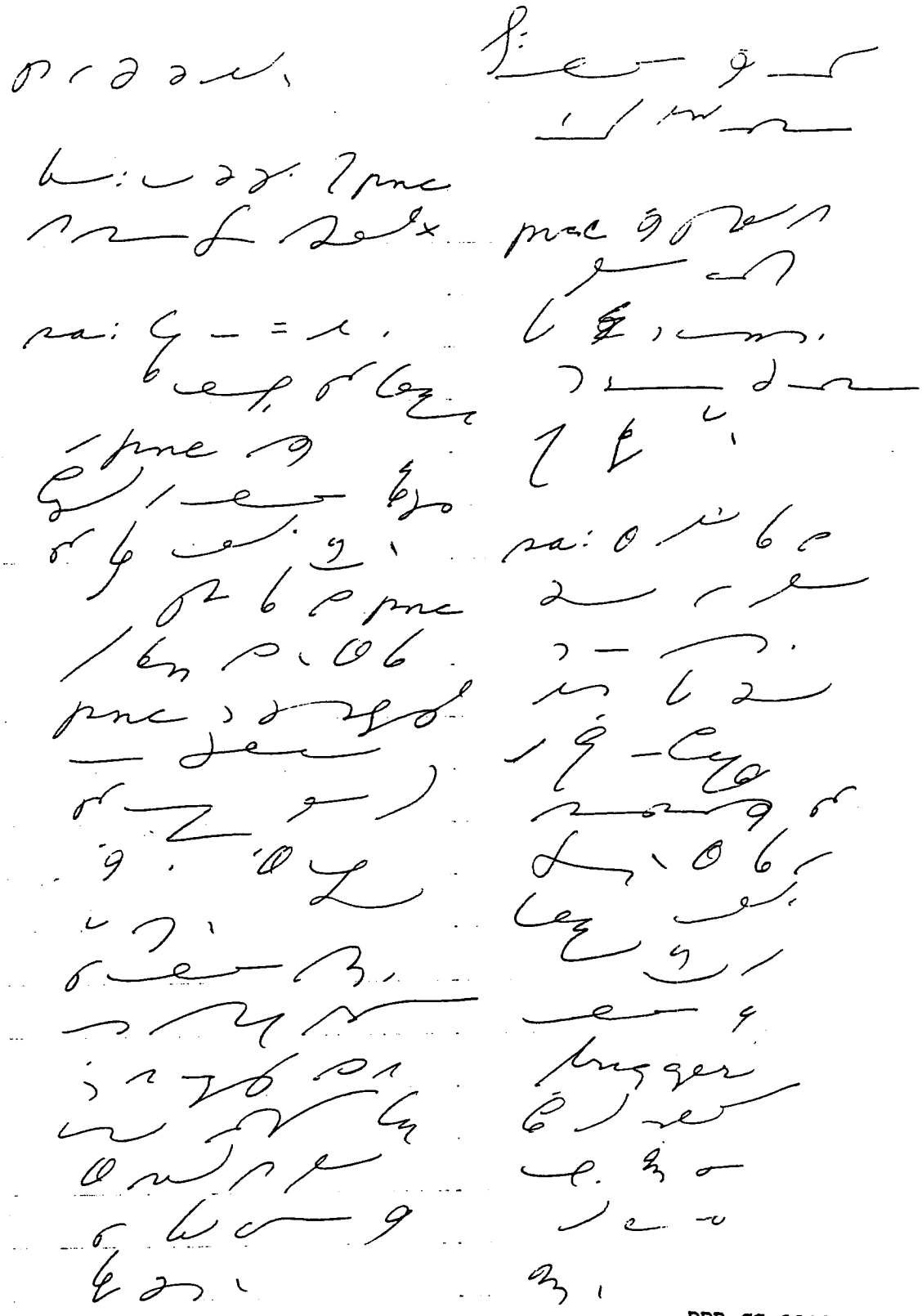


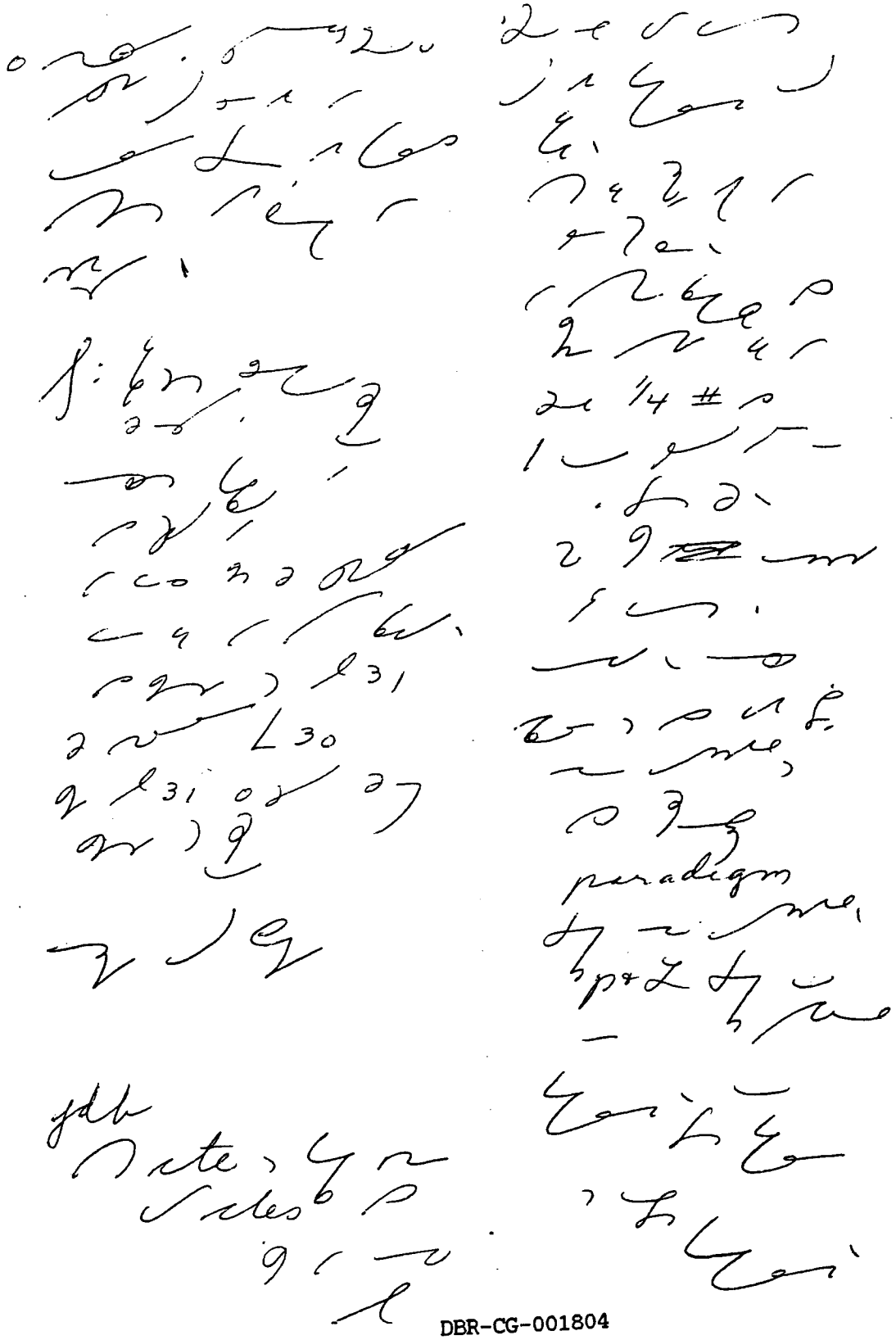




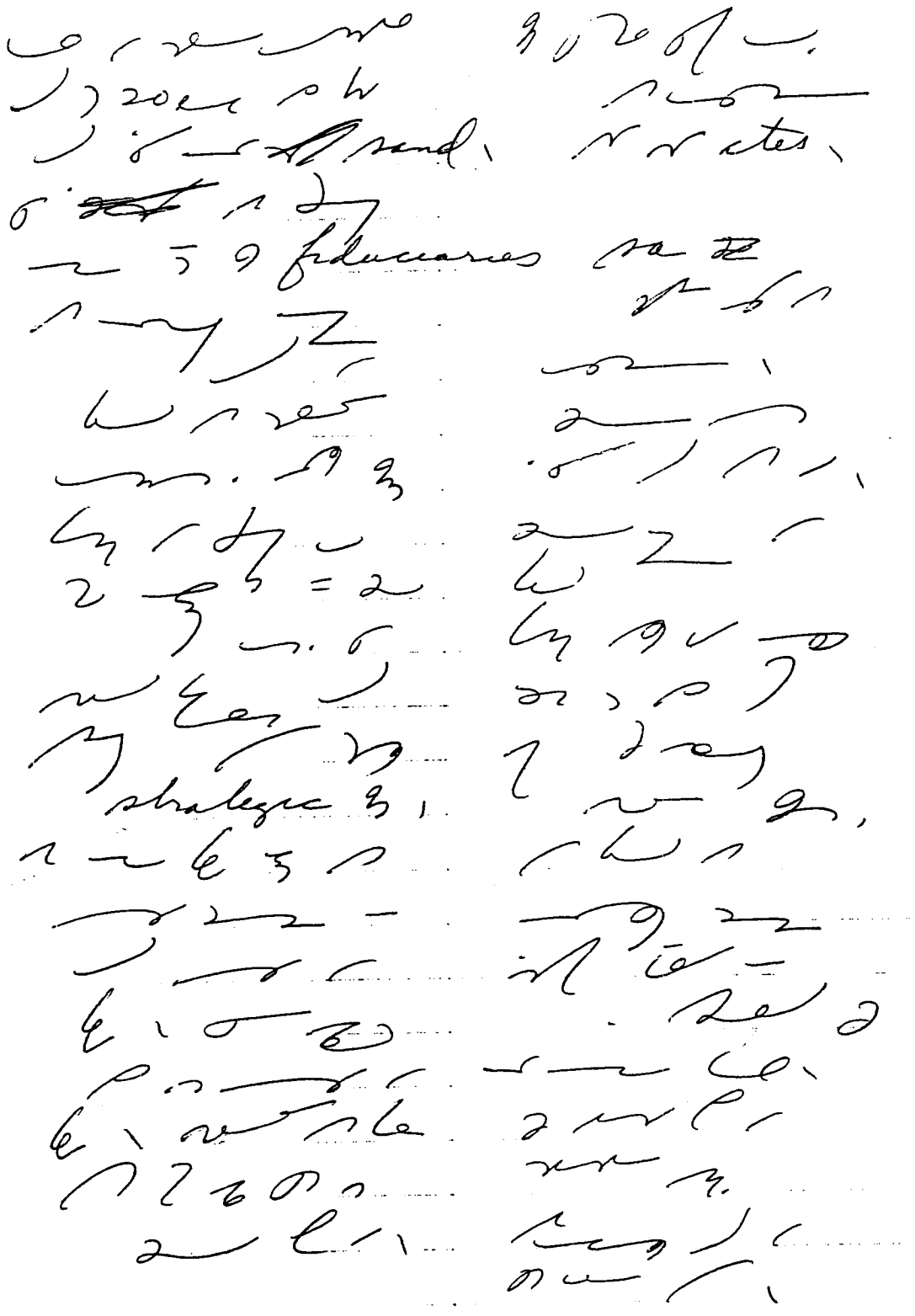


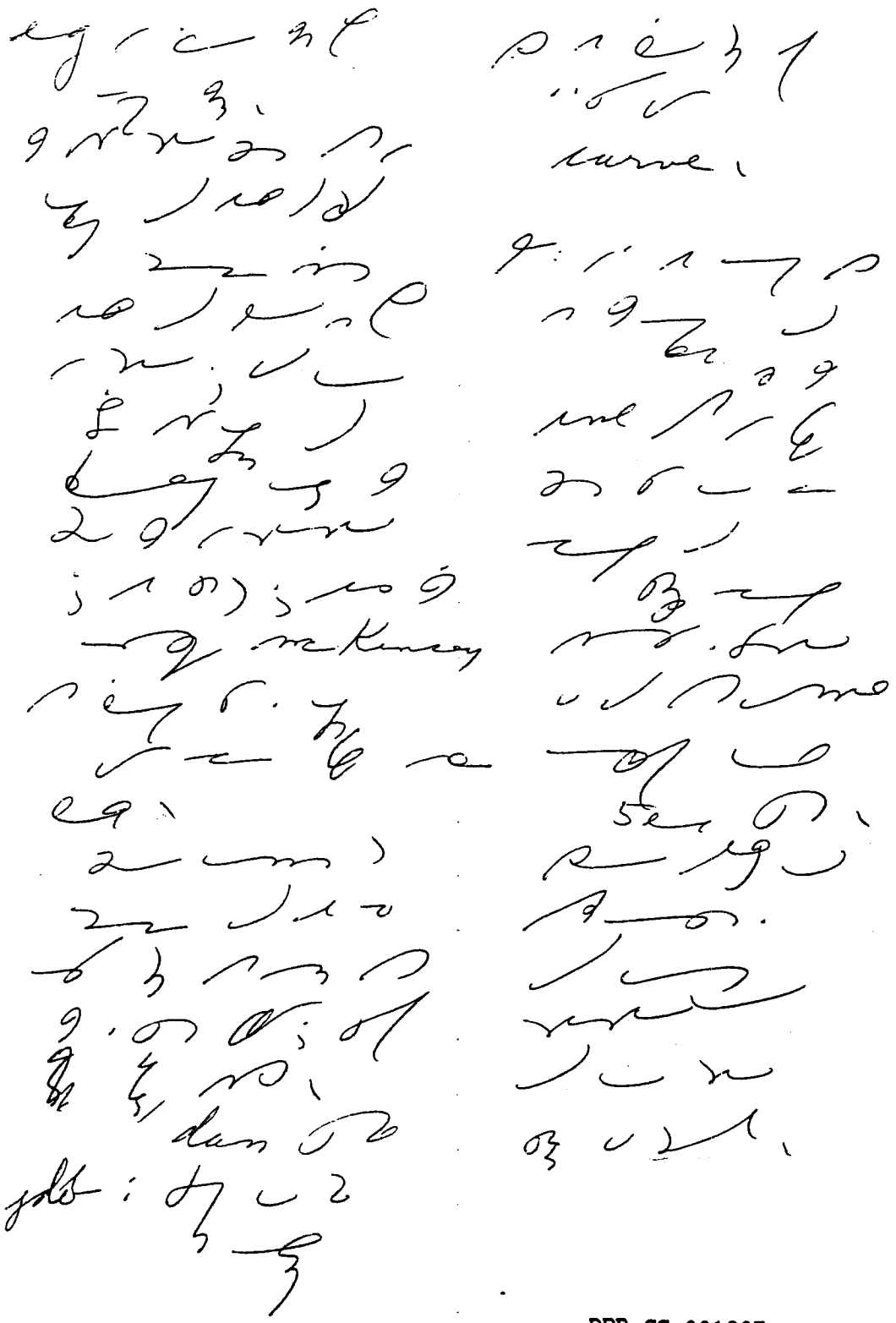


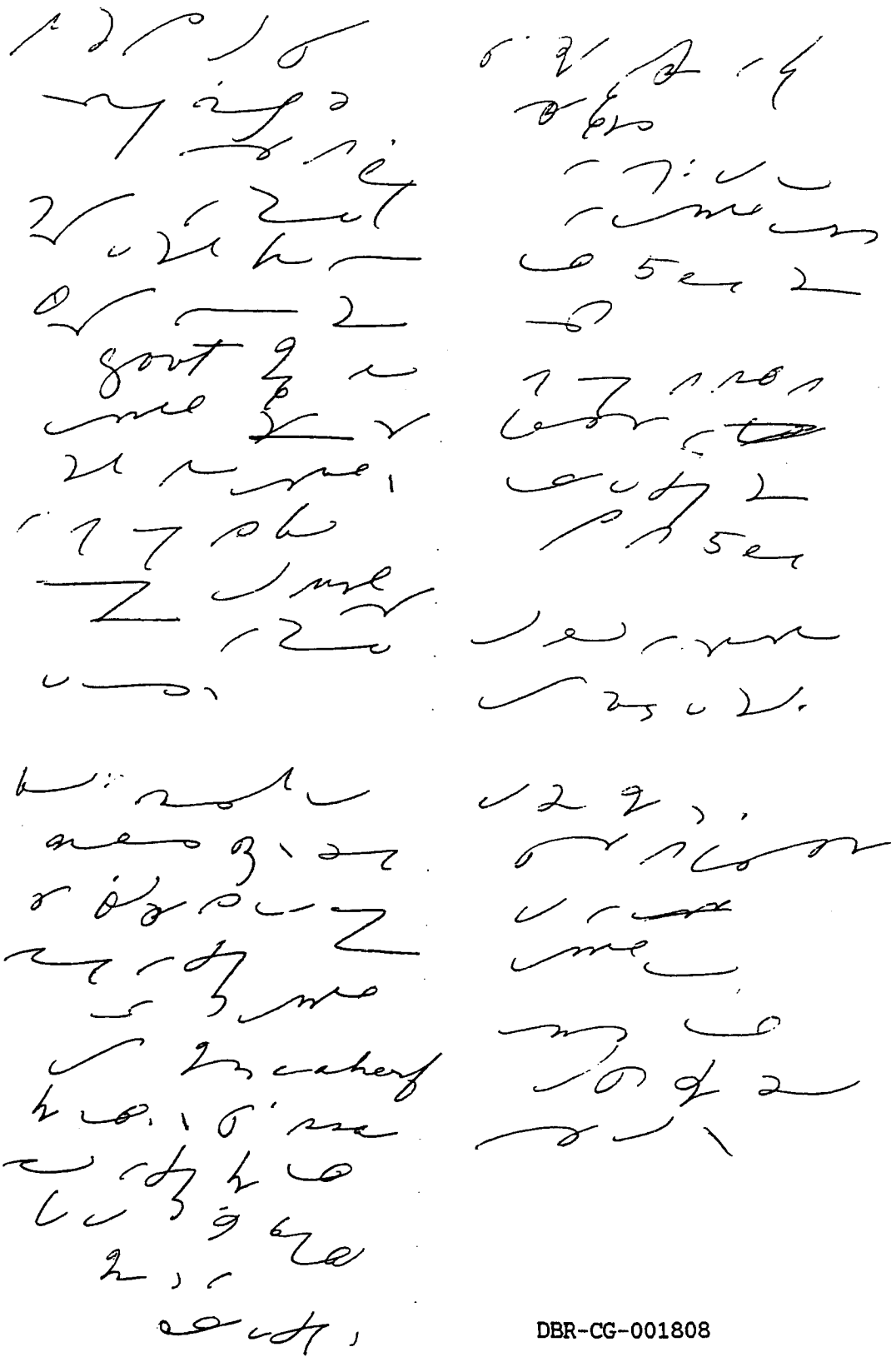


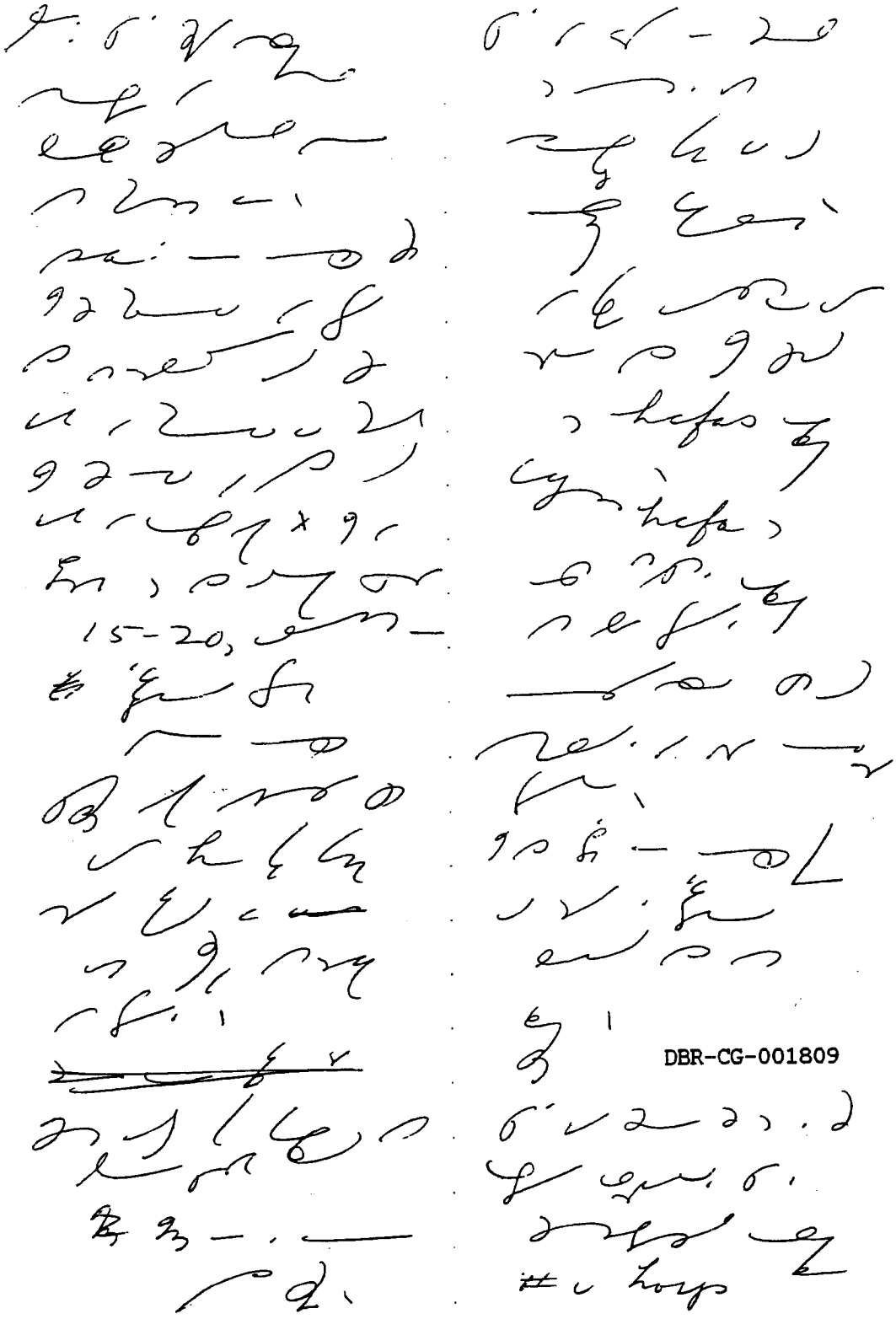


DBR-CG-001805

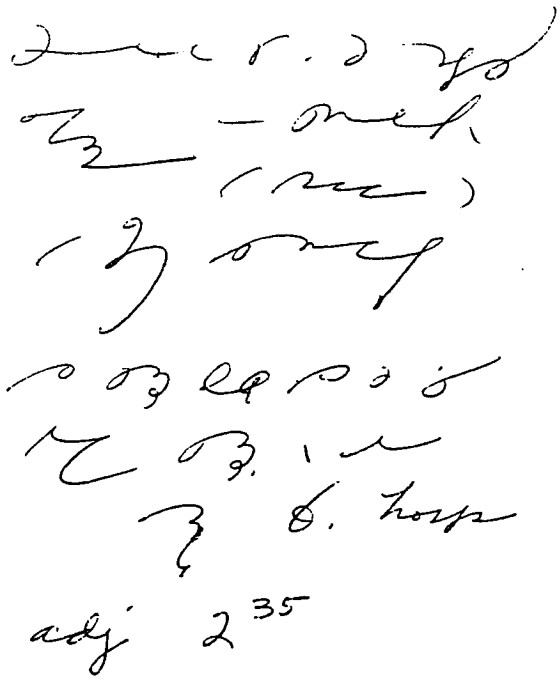








DBR-CG-001809



Transcription of Shorthand Notes of Carol Gordon - Finance and Audit Committee, March 11, 1998

NOTE from transctiptionist:
( ) means I did not write anything in that spot at the meeting.
_____ means I cannot read it now.
_____?_____ means I do not know who said it.

12:00
No additions to agenda from J. D. Barnes at the audit.
No quorum.
Both sets of minutes approved.

Results of Operations

Abdelhak: David has asked that Al Adamczak, responsible for financial statement preparation - I would like to let Al make a presentation specifically as it has to do with the performance to date and what the outlook so that we can assess where we are.

Adamczak: Page 22, Income statement - there is an impending divestiture of certain entities. Financial statements are set up to pull out entities that will be divested and show them on the bottom of the statement. Top of the statement reflects the statements of the ratios that will be ongoing, that we will focus on. These lost ( ) due to shortfall in net patient service revenue of $57 million. Most of it relates to the Delaware Valley hospitals and the AUMP returns. If you look at the activity on page 5, you will see from an admission perspective that AHERF consolidated admissions are ( ) less than budget and that contributes to revenue variance. If you look at Days, they are down 4%, and this leads you to believe that the Average Length of Stay is down from budget also. Look at cash flow statement; it shows we had net uses from operations of $100 million. Talked about capital expenses. It was funded by draw down of investments. Also paid $30 million for debt payments and that was funded through Letter of Credit borrowing. We are running fairly significant cash shortfalls from operations. From balance sheet, there wasn't anything major that happened. Big changes are in board designated funds. These are down because of funding investments. Outlook projections were for the second six months of the year. Western Region hospitals are projected to make $8-$9 million in the second six months of the year. Eastern Region hospitals are projected to lose about $8.8 million. University lose $7.6 million, AUMP $13.4 million, AHERF will break even $3 or $4 million from investments. There is (x) loss for the second six months as opposed to $70 million for the first six months.

Abdelhak: Needless to say, this is not a result that we can accept, and we are now embarking

on a $200 million improvement in the bottom line that we intend to outline by the end of this month. That involves $50 million improvement in Western, $50 million improvement in AUMP, $50 million at the University and $50 million at the remaining Delaware Valley hospitals. Will get this accomplished by the end of this month. Will also affect our restructuring expenses. Hope you will understand our desire to get all of this over with in this fiscal year so that we can look forward to a brighter year next fiscal year. Given the amount of the reduction that has already happened, $140 million, the only leeway I could give are the targets. We are well on our way to identify the reductions. We have tried to centralize the expenses and tried to reduce targets by centralizing expenses. The restructuring expenses don't leave us from a cash flow point of view because we have severance payments and other expenses, but there should be a significant improvement. There has been much that has happened since the first six months that has not yet been seen in terms of effect on financial results. Significant savings on the insurance program, significant savings in IS. We are making a policy adjustment in IS, and you need to reconfirm. Policy adjustment is to be at the ( ) each which takes you away from making systems work that no one else has made work so that when we see that systems are cost beneficial we will consider it for our institution. This has made us realize that a lot of expenses were centralized that should not have been, and we will decentralize them. For example, in Purchased Services, there were expenses that were accounted for and charged back to AHERF and we couldn't see what they were, so we decided to put them back in the Eastern Region and Western Region so that they can deal with them. Example: Purchased Services in "Medical Services", $3 million. Other things, e.g., in IS - the Data Center, the network, and the enterprise wide software applications will be centralized and will be accounted for in the regions. Another example is that we had under Nancy all expenses for Legal Services, and we are now going to adjust it and assign the cost for Risk Management and assign it to the insurance company and the other users of Nancy's services will have to make adjustments about what their needs are and work it out with her. Certain core control functions get assigned to the areas. Just trying to make sure that where the responsibility is the authority is also. We tried to make some sort of centralization because of efficiency but the cost is lack of knowledge of all components so we are taking a different perspective. In many respects, that is an accounting adjustment, but it is an enabler for the executives in the regions to assess the elements of their costs. The team will have to outline their plans. Extraordinarily difficult time. Revenues of the hospitals in the East and West are history and have declined in a significant way, but the work is still here, so the cost hasn't gone away. Some of them are institutionalized, UPMC 80% transplantation. They are less conservative than we are. If you look at our bad debt as a percentage of revenue (ours is 7%), they are at 2%. Part of that is because of the significant components that is basically cash business. Our cash collections are higher than our net revenues that are projected on a monthly basis. Does that mean we are aggressive in reserving?

I would rather be aggressive for reserving.

Neuwirth: page 22, special items - could the change in methodology be considered an adjustment that relates to prior years? What assurance do we have that the current year will not be subject to this kind of adjustment as we go forth?

Abdelhak: Right now our cash collections are higher than our net revenues each month.

McConnell: With respect to the bad debt reserve methodology, Delaware Valley had different approach than Pittsburgh. Pittsburgh was more conservative. Coopers & Lybrand suggested that we get everyone on the same methodology. We did that this year, so it should be a one-time catch up. Second issue with respect to valuation allowance: As long as we have insurance contracts, we will have some fluctuation in our revenue number. This is caused when a patient comes in and gives one type of insurance, then after pursuing payment we find out that they have a different payment scheme that pays a different rate, so we have to continue to adjust. We have change procedures on the front end to clean up clerical mistakes and improve accuracy of collection so that we are only at risk from patient's misunderstanding of their insurance. Every day we have to revalue our receivables.

Abdelhak: I think there is a significant amount of that that is attributable to Centennial. Days outstanding, consolidated 62 days. When we compare to other organizations, they would be in the mid-70's. To get to the 62 number, Pittsburgh is below that and Philadelphia is above that. During the past year, we changed intermediaries to the Pittsburgh Blue Cross plan. In Philadelphia, we have other intermediaries for insurance companies that are slow, i.e., they don't pay.

Neuwirth: I think I understand the economics of what is flowing through the financial statements, but I am not sure I understand the economics of AUMP. Would be grateful for an explanation of what causes the loss in that group.

McConnell: As each practice was acquired, we negotiated with each physician in each market against competitors. I don't know that any physician took a pay cut, so to negotiate the practices, we increased their compensation. I am sure they paid themselves the maximum they could afford and we had to increase that to entice them to come on board and we have not always been able to reduce their expenses or operating costs, for example, because they are in Allegheny, the employees have to have the same benefits. The practices had part time workers or casual workers without benefits, etc., and some of these are costs. In the main, our physician contracts are 60% to 62% of revenue and in the for-profit arena they are 45% of revenue.

Neuwirth: Does that mean as we move forward in the future we will run at a loss?

_____? At the prior meeting, we will evaluate the practices' performance and take steps to deal with it. Goal is for $60 million improvement in that organization. 30/30

Barnes: Spent several hours on that company this morning. Five years ago, a goodly portion of the motivation was to use the doctors as feeders to the hospital. That part of the strategy was successful. 20%-25% of our admissions are attributable to that group. So it is important to us. When we made the decision to go ahead knowing we would lose money, the hospitals were in better shape to eat the losses. So now we need to get costs down to break even without negatively impacting admissions which are important to the hospital. We think there is still opportunity to increase referrals above where they are now. Very tricky challenge to the management to get costs down and keep effectiveness of the system in place because we need the referrals. It is a delicate problem to get it worked out.

Danforth: When we bring people on board to support those, we want to comply with the law, but when you go to do it on a contract basis rather than employee basis, the cost is lower.

Abdelhak: We are doing that wherever we can. In hindsight, would it have been better for us to contract out? Maybe, but we didn't do it.

Danforth: We should think about it going forward.

Abdelhak: Part of the increases in the compensation are the physicians taking liberty with what they receive on a pre-tax basis.

Abdelhak: Asked for acceptance. Moved.

Barnes: Think management team has made a tremendous amount of progress in the six months since we saw how serious this problem was. The numbers are dreadful and will continue to be dreadful during the year.

Abdelhak: Other than the four people in the room.

Abdelhak: There was a reference in here that we were divesting of certain assets, and it is important because our auditors are here to be explicit. Tomorrow we will ask our Trustees if they will permit us to sell six institutions in the Delaware Valley in return for sufficient cash to liquidate our obligations. That will only be for information and get their approval to release the knowledge to the public for legal and financial reasons. Entire agreement is subject to approval of the Board, and we anticipated we will give it to them prior to June 30. They will not be expected to act on it tomorrow. We had approval from Executive Committee of the Board when we realized they had an interest and we continued to negotiate. We had

several criteria, one of which is that the entity will have to work with us cooperatively; secondly, they would have to have evidence of significant financial resources so that they could assume the financial responsibility as principals. Three, they have to make a commitment; had to have a track record that demonstrated a commitment to community services, and to our commitment to education. Structure of the agreement satisfies all those concerns. We need additional financial information (fairness opinion) as well as opinion to other things that are remaining and that is still in progress. We have engaged Smith Barney to give fairness opinion. At this point, we are anxious to see how it is received and notify the Board on that as well. We will see how it is received by financial markets. Question as to why you don't see other bids. And we will say if there is a qualified bidder who meets Board requirements, then step forward. We will give press release tomorrow. Will give update on schedules and on the approvals required and will share other information that you want about it. All we want is permission to release the information. It is out there. Details are that we are not going to release the dollar amount, but it is $500 million, $400 million at closing. We will not release it until Board approves it. Approved.

III. C. Coopers & Lybrand Audit Plan

McConnell: Audit prepared with Coopers and internal management of the organization. They have reassessed the risks of the environment. Bill Buettner is here. Everyone knows him. Introduced Louis Testoni, who is the Managing Partner of Coopers & Lybrand and will talk about the planned merger.

Buettner: Turn to Page 35 - discussions over the past hour will summarize everything I wanted to say. In the past, we would talk about various issues and how we would address them from a risk assessment. Risks were very different than a few years ago when we are in acquisition mode. Everything we talked about Coopers has incorporated into their plan. Page 35 - have attempted to classify into three areas and how it impacted certain primary operations in the AHERF organization. Spent time in revenue funds management (cash flow, investments and management of debt), and compliance. Pages 36-40 is summary of what we view to be those risks. Page 41 - we talk in general terms about audit approach. Summary begins Page 42 and runs through Page 46 of each significant system of audit areas and how we will perform our audit work. Approach will vary from organization and area to area based on overall assessment. We will rely on controls and will perform certain testing in various areas. Thirty per cent of our time will be spent in the revenue area. In fund management, we will work with Mike Martin in terms of debt covenants. Will spend time in insurance and litigation. Have provided with a lot of information; different format.

Neuwirth: This is the clearest and most comprehensive audit approach than I have seen in a long time. You should be proud.

Buettner: Lou will spend two minutes talking about the people on the engagement.

Testoni: Consistently committed to our clients that our resources get to the client issues. Page 48 - talked about engagement team. We also recognize that AHERF is going through a change, so we need to change our approach, and we hope to bring some value to you this year as you work your way out of these problems.

Buettner: Page 49 is summary of fees by report.

Testoni: Have had lot of questions about merger of Price Waterhouse with Coopers & Lybrand. Merger is still on. Still waiting regulatory approvals in many countries. AHERF is a very important client of the Pittsburgh office and their firm. Trust the merger will be an invisible process to you. Want to give better service. Two firms will have $600 million health care industry practice. We would like to continue as your audit firm, both short term and long term.

Danforth: Asked about total employment. 38-40 each worthwhile 1^3 billion. (Transcriptionist's note: I have no idea what this "1^3 billion" means, but it was written that way in my notes).

Resolution moved and seconded.

Update on Intercompany Borrowings

Barnes: Going back some time ago, in response to the borrowings that were done in the fall, Sherif suggested that we establish a Loan Committee and develop some orderly procedures for this. However, I have decided that we would defer the time investment because management has higher uses for its management time than to work out a loan system when we are not in the borrowing mode. The procedure will get done, but I don't want them spending time on that now when they should be cutting expenses. Etc. Loans are in the loan repayment mode now.

McConnell: Page 57 is status of intercompany balances as of January 31. Highlighting June 30 number, $27 million for Western Region and AHERF due $43 million plus. In January, Western Region are now due $54.5 million. AHERF number grown slightly. Eastern Region hospitals and University have paid a substantive portion of their loans back. Coopers & Lybrand will be verifying this schedule. Bill verified that they have verified the accuracy. Bill said Yes, they sent a report out. The numbers are accurate. It is important to know that the repayment mode is

continuing, and we are pursuing other strategies to repay other loans in the West throughout the fiscal year.

Abdelhak: Since that report was prepared, there was another $18 million that has been paid so that $54 is minus $18, but it was in February, so we couldn't show it in this report.

McConnell: We have not had the need nor the opportunity to call a Loan Committee meeting because we have been repaying, so we didn't have a meeting.

Abdelhak: The issues that Mr. Barnes mentioned.....certain sources of the media who have little to do with reporting facts have stirred up a certain amount of emotion about dollars going from the West to the East and has created a lot of distraction for Tony. The ownership of the money doesn't change, and it earns an interest. Notwithstanding those facts, we want to take that issue away so that he can focus on things other than these brush fires.

Barnes: I have no problem with intercompany loans. All companies do this; there is no legitimate issue. The issue is: are the procedures sufficient for reporting, etc.

Tab 6

Schrecengost: We have periodically updated the Audit Committee on the status of this government audit initiative. Report is to apprise you of things transpired since we brought it to the Audit Committee. In addition to the issues, it is important to let you know that we have moved ahead in our own request from the government to respond to information needs they have and have joined a lawsuit with the AAMC. We are still working cooperatively with the Inspector General's office to further the audits they are working on. We have provided them with a story of AHERF which explained the scope of our system and how we relate to our physicians and how these relationships differ among the hospitals. Also met with a number of audit firms to see their qualifications in assisting us in the PATH II audit. We have hoped that the AAMC lawsuit will change the government's position but it hasn't stopped our cooperation. We think the DPW at the state level is seeking to piggyback from the other audit. Etc. That is, when the Feds leave, the state is trying to recover overpayments. Two hospitals have come through these audits with a clean bill of health.

Kaye: Haven't seen any letters to any institution and we think it might be a while until they do. There has been a lot of negative reaction. HAP believes the rules never existed.

McConnell: Concern that I have is that it is very easy for them to do because it falls back on the audit process. They pull 100 charts and then extrapolate the error rate to all of this business for five years.

Dave thinks we will be under that attack for a long time.

Abdelhak: The point is, in many instances, other payors are now using the Medicare payment schedule as their own, and wherever Medicare goes, they go and they are entitled to recover. It is another form of reducing payments.

Y2K

Dionisio: Observed that AHERF, like every other institution, is faced with a monumental issue. Assure the Board that we have been proactive and started addressing this issue in 1996 and more in 1997 by creating a Project Team of seven people who were relieved of other responsibilities. We are taking inventory of all systems. See Page 8, Tab 7 to note that we have identified ( ) systems that need upgraded, 357 which are mission critical and those are the ones where we are devoting most of our attention. On Page 9, we verified 159 out of 357 as being converted as Y2K compliant so we are a long way toward providing assurance against the risk. Page 10, we surveyed other organizations in the city and learned that everyone is facing multi million dollar obligations. Our costs over the three year period will aggregate maybe $20 million, including applications that need to be upgraded for only the Year 2000 issue and added a factor for applications that we chose to upgrade for other reasons. As an organization, we are responding to the task. Also observe we have created a Steering Committee of executives who meet monthly with the executive team. Diane, any feedback on how the organization is responding?

Schrecengost: Our Director of IS Auditing sits on the oversight committee. Approach has generally been to provide status and go through the systems individually to see what has been accomplished in getting these certified. We need to understand that there are a number of systems that are not under the direct support of the IS group and there is a decentralized responsibility for those systems and that responsibility lies with the Presidents of the entities. They all responded to our inquiry with their status, but it is important to note that there are others who are responsible for this situation in our organization.

Danforth: Will we be ready?

Schrecengost: It is a deadline that doesn't move. We need to develop a contingency plan for those that we can't get to. There is a partnership with your vendors. This may be

the next hottest wave of litigation.

Dionisio: In answer to "will we be ready"? We are ready. We have identified mission critical applications. Have certified that 45% will be Y2 compliant. We are testing those systems by creating a special date on CPU. We are confident that our mission critical systems will not fail us, however, as an organization, there will be problems. They won't be IS problems, but I am certain there is a medical device that will be missed, an elevator or parking control arm. We will not be shut down and patients will not be affected. I am confident.

Barnes: I think it is important, and this should be on the agenda every meeting. This report did not give me any comfort at all. I saw another report that was calculated at days, 635 calendar days, about 620 days; if you have 300 things to work on, you need to work on one every day. If you talk about it in terms of calendar days and then business days, it is very close.

Dionisio: I appreciate your concern, and we all share your concern. We are significantly advantaged by the decision the Board made a number of years ago to rely on vendor software as opposed to our developed software. We have very little mission critical software that we developed. There will be applications that will fail, and I don't think they will be mission critical.

IS Benchmarking

Joseph Dionisio: Did this benchmarking analysis for my own benefit a few months ago and took a different approach. In the past, we have compared ourselves to other healthcare organizations. Health care usually lags behind other industries. We found organization that produced benchmarking analysis that other commercial organizations rely on, and we compared AHERF. Will not dwell on specifics other than to observe then to say that AHERF spends a less amount on IS than other commercial organizations in the United States. It is about $9,000 per end user. We spend about $2,000 per end user. Nearly 80% of our employees rely on information technology daily. Average is 60%. Analysis reveals that we spend less on our capital investment. And while we have higher turnover, our pay scales have lagged behind and we have recognized that recently and are making some adjustments. From a cost standpoint, we are spending less than most organizations. Regardless of what we are spending, what are we getting? My perspective: currently we embarked on a strategy of clinical and academic vision to move AHERF to the leading edge with respect to critical systems, recognizing that the recent emphasis has been financial and administrative systems. Today all financial and administrative systems are operating on the same system. By contrast, when I joined in 1989, AHERF had 5,000 employees and we supported Payroll

and Human Resources with five IS people. Today we have nearly 30,000 employees, and they are being supported by the same five IS people. Dwight Kasperbauer shares my astonishment at that information. Same is true with respect to General Ledger systems. Those systems are referred to as legacy system. We have trailed in the clinical systems. As Sherif mentioned, we are taking a new look at that, given our current circumstances and our substantial investment to introduce second stage clinical systems. Asked for Mary Anne.

Abdelhak: Let me explain how we are structured for the Committee. Unlike other organizations, we have our IS service personnel supporting the data processing, the network, and the legacy applications, and we have another group whom we refer to as the data base administrators who are responsible for a variety of disciplines and they work for Mary Anne, who is responsible for all applications outside of the legacy. We also have another group of people who are responsible for research & development, so when Mary Anne speaks, she speaks on behalf of the users.

Darragh: I am not an IS professional. I know just enough from a technology perspective by challenging them from the user perspective. Need to share with you that it is very difficult to make one statement about the user perspective. Within our system, given its size, we have a variation as to what their expectations are. Have a lot of clinical staff who are dealing with high technology every day and find it difficult to put a pen to paper, so we are dealing with a differing level of expectation. Another issue is that many of us have come to take technology for granted. Never think about network support, etc. Especially given what Joe shared relative to what we are spending, we have clearly made a lot of strides toward achieving a base level of clinical functionality. At times it has been a difficult process but very rewarding process to bring users together. It is a disappointment to everyone that we will have to take a different approach to a second level of systems but there is value to that in that we have tried to devote time. What we can learn from that as what are the true benefits of our work. Need to understand from a user perspective and the costs associated with the benefits. There are days when a system is not as reliable as we would like it to be, but we have had improvement from IS perspective and user accountability has increased in our systems.

Abdelhak: I would like Joe and Mary Anne to speak about some of the things that have been recently installed, i.e., Internet, use of uniform system to connect all administrative offices, talk about the Invision, Signature, additional platforms, Pharmacy systems that is going on; it is now my view and my guidance to them and David Gur is that we really focus on implementing all those systems in one place first beyond the platforms of Invision and Signature. Please explain what is there.

Dionisio: Good segue into the status report on IS where we have tried to illustrate where we

are on our applications. We really are far advanced when we compare ourselves to health care organizations. We have the statewide network, everyone is on e-mail, we communicate electronically, many areas are paperless or on the verge of paperless; there is a cultural issue from specific applications: Intranet phone directory on internet, e-mail, all facilities have latest technology for distributed systems, radiology departments are computerized, core applications is SMS produced, bill application for faculty practice plan is a product called Signature; 65% installed micro medical and cardiology area. Emtek is nursing documentation product. It is being piloted in med-surg unit in AGH. Pharmacy at AGH.

Darragh: Those are the core systems that we are committed to installing on all campuses. It is important to note that at AGH most of that level of functionality did exist. In Delaware Valley, a lot of this does not exist at all or exists in an antiquated system or not at all. In the Delaware Valley, this has been a major enhancement. What we need to do in Pittsburgh is to look at physician order entry where we have on line support. Need to make AUMP practices have access to the hospital information that they can. We will be offering a lot of additional functionality.

Dionisio: Moving to IS Department and service responsiveness. My perspective is that the level of satisfaction with IS is significantly reflected with your last experience with IS. Talked about calling the Help Desk. There is no doubt that as we have contracted costs, IS has historically shared in those reductions, and to some extent we collectively pay a price. Our people are motivated, well intentioned. Number of PCs grown by 7,000 in the last 18 months, which is almost 100% increase in the number using PCs. We have not added substantial people in our department.

IV. E. <u>Management Report on Investments.</u>

__?__ Page 81-94 is the management report on investments covering (period). Report gives report on investments of the organization. For the most part, they indicate that results have been competitive for funds that have been managed. Point out that there are some differences in terms of performance in that we have not consolidated all funds into common management structure. That transition will occur in throughout the next year. Page 90 begins to talk about an event which is somewhat ancient now and that is Asia turmoil and have included that so that you might see what we look for. You could see what other institutional clients are doing.

Danforth: What do we have investment in securities vs. investments?

Martin: Turn to Page 90, there are some pie charts. Chart gives allocations.

McConnell: Any asset classes that we invest whose financial impact is reflected in bottom line we have begun to reduce our exposure in equities as opposed to....

Danforth: What do we pay our Managers?

Martin: On average, it is 20-25 basis point range. Lower for fixed income, higher for investments.

IV. F. Audit Services Activity

____?___ Four months since we reviewed results. Included is summary of the activity. Any questions? Can provide copies of full audit report. Mention one item that we now have in place, our Billing Compliance Officer. Have centralized responsibilities for billing compliance. Have unique individual in Christian Presley Ford, comes from Office of Inspector General where she negotiated health care settlements. Has done well to work with audits that are already going on in organization. She is a lawyer and a nurse. She gives a great deal of credibility. We will be making reports from the Office of Billing Compliance to this Committee. Danforth asked about what kind of compliance.

IV. G.

Martin: Cash disbursements are presented - check or wire disbursement. Paul Neuwirth asked about Pyramid.

Sanzo: It is a partnership of five hospitals and five groups of physician investors to collectively accept and manage risks. At the time we created the partnership to capitalize it at the amount of $30 million per hospital investor. (cg note: Not sure if that should be $30 million, $35 million, or $350 million). This was an amount of capital that became due in the fall for the amount that was shown.

IV. H.

McConnell: Pages 118, 119 is a suggested calendar for activities of this Committee. This is the first time the Committee has met on a combined basis. To show when we think it is appropriate to bring items forward. If you have any questions regarding other items or timing, please share with me now.

Mr. Barnes added one about Y2K report routinely. Standing item.

Other Items:

____?____ Resolution based on discussion with this Committee today. Need to take to AHERF Board tomorrow for their consideration. Approximately a year ago we entered into a line of credit arrangement with Mellon that was consolidated at AHERF for all operating units. Saved money on fees and interest. As the issues in the Delaware Valley surfaced over the last 6-7 months because of their financial performance, we have not met administrative covenants. We are not in default from administrative standpoint in payment standpoint. Mellon was not able to keep the banks interested in staying in the deal. We are to the point now where we believe two of the banks want out and have the right to call the loans. We have been working with Mellon to find a way to cure the problem. Mellon is willing to put money into the program and would change the line to a term loan that expires on June 30, 1998. This line is contemplated to be fully retired with the sale of the assets in the Delaware Valley. Issues are if something would happen. Second is they have asked for collateral if the Board tomorrow does not authorize us to provide collateral then we would have to retire loan in 30 days. If we agree to provide collateral, we can move forward. Mellon has agreed to put additional money in to help solve the problem. We are working with PNC and MBIA and have a call in to First Union to ascertain their interest. If the board allows us to enter into the agreement with Mellon tomorrow, collateral in terms of cash and investments that we have on the balance sheet. Out - Toronto Dominion, Bank One of Ohio. It is not a situation that I like to present to you, but we find ourselves in it; if Board approves, we have some meetings scheduled to finalize the documents. If a better answer comes along, we will pursue it.

Motion and seconded.

Neuwirth: Second paragraph, there was an event of default. When did that occur?

Martin: September 30. We thought we had them on a stand still basis, especially with the negotiated sale, but when the two banks dropped out, they got nervous.

Abdelhak: This is the first time we have used Mellon; I asked David to use Mellon. We have always used PNC, and quite frankly PNC, with a phone call within 48 hours, will arrange anything you want. I wanted to support the other major bank in Pittsburgh as best we could, and it has not turned out the way we thought.

Neuwirth: Are we setting up PNC to come back differently?

Abdelhak: Probably not. There is a relationship with the principals at PNC that is absent at Mellon, specifically with the Chief Lending Officer. I do not believe that PNC would pursue that. I believe PNC is significantly more familiar with the management team and has a high level of confidence. With Mellon, this is a new group to them; it is unfortunate that it has occurred at this time, because I want to deal with both of them as best we can.

McConnell: Mellon has more than $1 million trust income. PNC has agreed to deal on this but is looking for some fee income to be shifted over.

Abdelhak: I don't believe they feel the deal is not going through but feel there has been inappropriate communication with the banks. I believe the principal lending officer at Mellon was trigger happy and started raising issues when there were no issues. He created at atmosphere of doubt and when it is the lead bank, it is pretty difficult to help the others understand.

McConnell: Specific example - we needed a waiver. Mike prepared it. They signed it. The only issue we agreed on was the time period. They asked for December 31; we wanted June 30. After December 31, he said we never asked for waiver.

Moved and approved.

Barnes: This Committee is probably one of the Committees that has the most deep awareness of the organization and its problems and opportunities. This was supposed to be the turn up year. The great surprise that everyone got was the first quarter numbers which are turned down in a big way. So I have looked at the organization a lot. My concern is that what is happening in our industry is that we have massive paradigm changes in our industry. Profit and Loss changes are not temporary problems. Our big problem is revenue problems. This industry grew massively since World War II through the mid-80's. Then came Medicare. Two of the legs are shorter. Blue Cross/Blue Shield funding (or the private sector) is funding downward. The industry cannot count on the revenue that it used to get from that leg. Second leg was the decline in the Medicaid program which happened retroactively. And that has cut our Medicaid payments. Talked about President putting Medicare on same basis as Medicaid. My bottom line on this is that I think things are moving so fast and so dynamically that this committee, we

should recommend to the Board and to management the retention of an outstanding management consulting firm to work with us on our strategic plans and operations over the next ten year timeframe. I think this program should be undertaken in a broad sense, consider revenue, consider structures, consider functions. We do not want to play this like the steel industry and for 20 years they put their head in the sand. I think it is very much in our interest as fiduciaries to encourage management and the Board to start looking at these issues, because the changes are so massive - we are working with current problems and do not have time for the strategic issues. It is in our best interests to get someone in and get the best. I am concerned that you get the best. Wanted to bring this up to see how you feel about it. If you agree, I would be willing to recommend to other Committees.

Abdelhak: We do not need to recommend. We will go ahead and do it. We will inform the Board because that is what my sense is that you have to be very careful you are not asking the Board to engage someone who would be interpreted in a different way in the marketplace. We talked about the structure causing dislocation and the use of our time. That is the whole issue about intercompany issues. As to the future, we can do the research and try and find someone who can try and tell you about the future; what will happen to the revenues and challenge ourselves as far as the structure; it is useful; Tony has engaged McKinsey to help with a review of the non-patient care areas. We will look for someone, and there is no need for us to consider that as an action item; I would be opposed to that.

Danforth: Agree.

Barnes: Changes are so massive that it is hard for us to be ahead of the curve.

Danforth: Think it is important that you, as Managers, and we, as Trustees, do the best we can with our own knowledge and outside knowledge to get a picture of what this industry might be like five years out. That will drive our decision- making and organizational structure and our future uses of funds. It is very timely, and I would encourage whomever we get to help us understand the flow of funds better than I understand them from governmental agencies state funds to our industry. Think it is important that Board management and Trustees understand the flow of money.

Neuwirth: Comments are extremely useful. Seems with hindsight that our management calls the changes in the industry and the effects on AHERF just right. I think Sherif called the changes just right but what has surprised everyone is the rate of change. I think e should define the job quite specifically. The question: What will the industry look like five years from now? It is important to try to predict the rate of change from today to five years. And third, the structure and the sources of

funding. What we are after is an attempt to predict what the industry will look like and act fast. We will get there.

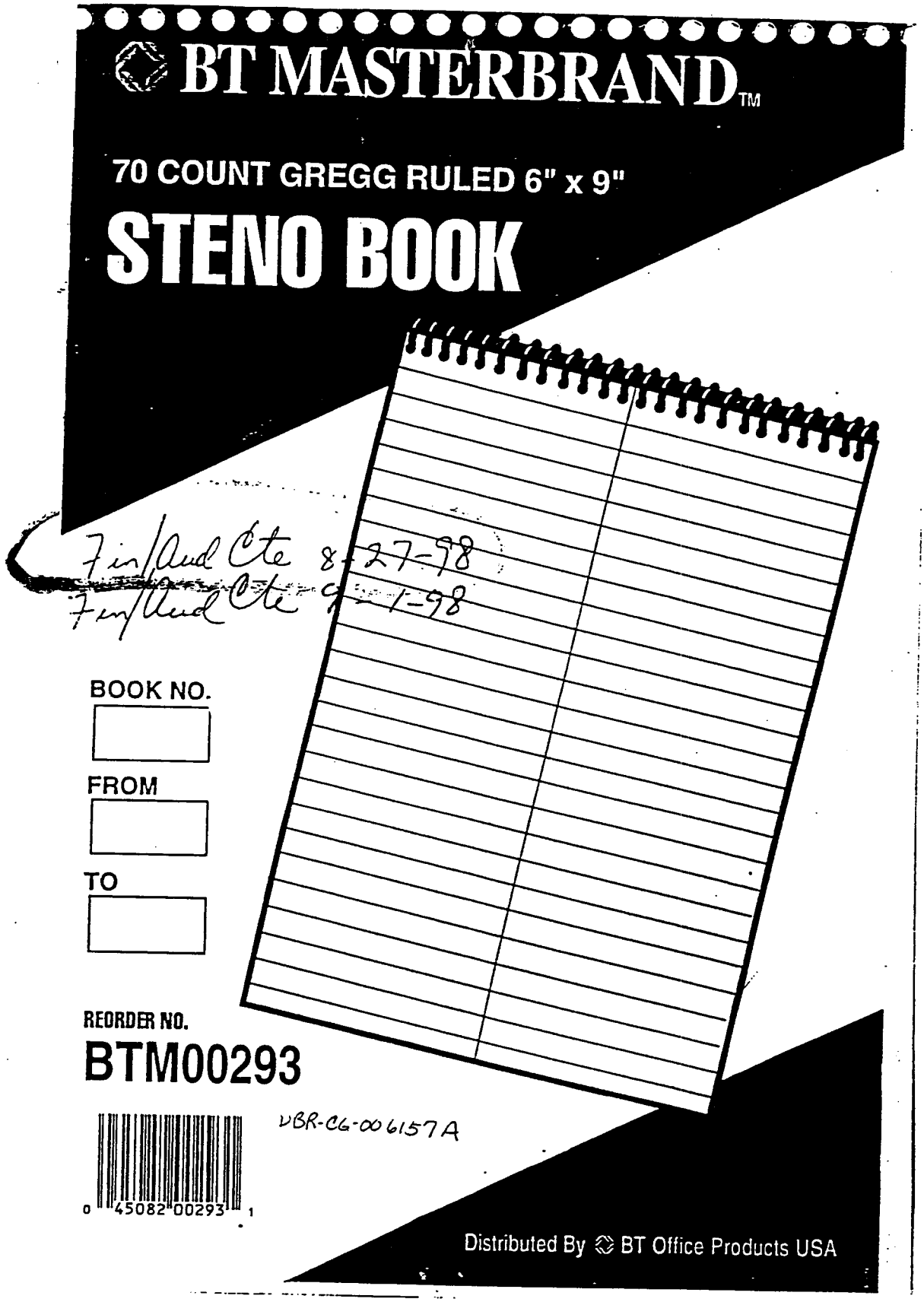
Danforth: I think we should carefully craft the areas we would like them to focus on.

Abdelhak: In my view, if we follow the path that you started and see what is the flow of funds as we know it today and what is it likely to be? If the expectation is that there are another 15%-20% reduction in hospital payments, then my advice would be to get out of the hospital business because you would spend all your savings to stop the bidding. We can therefore be prepared to deal with those issues in a more timely fashion. I think the system in Philadelphia is going to collapse because of their massive problems. The best indication of the future that I have found is HCFA's research projects. HCFA is now undertaking research to test bidding Medicare out and granting it to the lowest bidder. If that happens, in my judgment there isn't a hospital around that can survive. I think what we will see is a very rapid restructuring with a significantly larger number of hospital failures with a significant improvement in utilization. The risk is the effective technology. Key access areas that we had trouble accessing. There are considerations buying hospitals.

Adjourned, 2:35 p.m.

cg
wp:10121
Transcription date: 10-19-00

EXHIBIT 17


BT MASTERBRAND™
70 COUNT GREGG RULED 6" x 9"
STENO BOOK
Fin/Aud Cte 8-27-98
Fin/Aud Cte 9-1-98
BOOK NO.
FROM
TO
REORDER NO.
BTM00293
0 45082 00293 1
VBR-CG-006157A
Distributed By BT Office Products USA